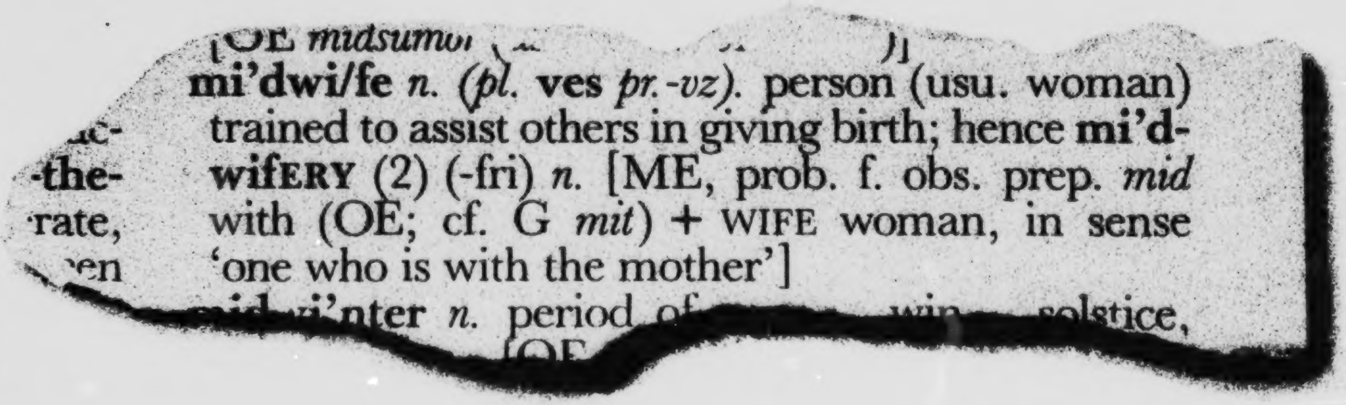

[OE *midsum*

-the-
rate,

mi'dwi/fe *n.* (*pl.* **ves** *pr.-vz*). person (usu. woman) trained to assist others in giving birth; hence **mi'd-wifERY** (2) (-fri) *n.* [ME, prob. f. obs. prep. *mid* with (OE; cf. G *mit*) + WIFE woman, in sense 'one who is with the mother']

mid-wi'nter *n.* period of ... solstice,

REPORT OF THE TASK FORCE ON THE IMPLEMENTATION OF MIDWIFERY IN ONTARIO

1987

Definition taken from the seventh edition of the *Concise Oxford Dictionary*

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of Midwifery

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Gentlemen,

Pursuant to Section 9 of the Ministry of Health Act, Revised Statutes of Ontario, 1980, Chapter 280, we are pleased to submit The Report of the Task Force on the Implementation of Midwifery in Ontario.

All of which is respectfully submitted.

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EXECUTIVE SUMMARY

Appointment of the Task Force

On January 23, 1986, the Honourable Murray Elston, the Ontario Minister of Health, announced the government's intention "to establish midwifery as a recognized part of the Ontario health care system" and that midwifery would become a regulated health profession. He announced the creation of a Task Force on the Implementation of Midwifery in Ontario, to make recommendations to him and to the Honourable Greg Sorbara, Minister of Colleges and Universities, with respect to:

- how midwifery should be practised in Ontario;
- how midwives should be educated;
- requirements for entry to practice, scope and standards of practice, and governance of the profession;
- whether midwives should operate as independent practitioners or as part of an organized service;
- the setting in which midwives should provide their services; and
- optimal relationships between midwives and physicians.

Several factors led to the decision to give legal recognition to midwifery. For some time, interest in midwifery had been growing in Ontario. Some women had come to believe that maternity care was overly controlled by the predominantly male medical profession — obstetricians who regard every pregnancy and birth as a potentially pathological event. They believed that midwives would provide more holistic care, in which pregnancy and birth would be regarded as healthy events, greater attention would be paid to their psychological and social needs, and resorting to such medical interventions as caesarean section would be less frequent. The number of midwives practising in Ontario was also growing, and they were increasingly effective in communicating their case for recognition to the government and the public. The attention of the wider public was focussed on midwifery (and the separate issue of home birth) in 1985 by an inquest into the death of a baby boy two days after his midwife-attended birth on Toronto Island. The coroner's jury recommended that midwifery be granted legal recognition and become incorporated into the health care system.

These local events reflected the renascence of interest in midwifery across North America and the rethinking of maternity care taking place in much of the developed world.

The Work of the Task Force

The Task Force gathered information about how midwifery is practised inside and outside Canada, how Ontario midwives and other health care providers envision the integration of midwifery care into the health care system, and how the public perceives its needs.

We consulted extensively with organizations representing physicians, nurses, hospitals, health sciences educators, and midwives, and we held public hearings in Toronto, Ottawa, Hamilton, Windsor, Kingston, London, Thunder Bay, Dryden, and Sudbury. Submissions were received from more than 500 women's groups, consumer organizations, and individuals. We assembled an extensive collection of literature on midwifery and selected aspects of reproductive care. To investigate existing midwifery resources in Ontario we commissioned two surveys, one focussing on nurses, the other on midwives currently practising outside the official health care system.

Members of the Task Force visited midwifery schools, practices, and regulatory bodies in Denmark, The Netherlands, England, Scotland, Wales and the United States. We chose to visit places where midwives function autonomously and have clearly defined roles in the health care system, as well as places where midwives have difficulty functioning to their full potential and find their roles threatened or not yet fully realized. The knowledge of what has and has not worked elsewhere has guided our thinking about what should be attempted in Ontario.

The Current System of Reproductive Care

As the existing system of reproductive care is the context into which midwifery must be integrated, it merited investigation. Currently, a pregnant woman in Ontario is almost certain to be cared for during pregnancy and birth by a physician. While in the past this physician was likely to be her family doctor, today he or she is more likely to be a specialist in obstetrics and gynaecology. In 1985-86, general practitioners attended 31.5 per cent of all deliveries, while obstetricians attended 67.3 per cent. General practitioners attended a larger proportion (43.9 per cent) of non-operative vaginal deliveries than of all births, but obstetricians, who are specialists in high risk pregnancies and complicated deliveries, nevertheless attended 55.7 per cent of vaginal deliveries.

Nurses play a variety of roles during the different stages of the reproductive cycle. Nurses employed in physicians' offices assist in the provision of pregnancy and postpartum care. Public health nurses teach childbirth education classes, assist women with high risk pregnancies to obtain medical care, and make postpartum home visits. Nurses employed in hospitals care for women during labour, birth, and the postpartum period.

Although the midwifery profession has not had legal recognition in Ontario for more than a century, midwives have continued to exist and are practising in Ontario today. There are several different groups of midwives. The results of the survey conducted for the Task Force by Norpark Computer

Design Inc. indicate that there are approximately 50 midwives currently practising in Ontario outside the official health care system. In-hospital midwifery care is offered at the Chedoke-McMaster Hospitals in Hamilton in a pilot project jointly run by the Hospitals and the McMaster University Faculty of Health Sciences. Nurses employed by the federal government provide comprehensive pregnancy and postpartum care and emergency labour and birth care to native women living in the far north. Although these nurses are not recognized as midwives, the midwifery training some of them have is regarded as invaluable.

Ontario's perinatal and maternal mortality rates have improved dramatically over the past 35 years. They compare favourably to rates in many developed countries. However, the province's caesarean section and operative delivery rates are much higher than rates in many European countries. How satisfied women are with the current system of reproductive care is very difficult to gauge.

Guiding Principles

In making our recommendations we have been guided by six key principles.

1. Public Protection

The users of midwifery services — women and their babies — must be protected from unqualified birth attendants and unregulated practice.

2. Responsiveness

Women in Ontario have sought midwifery care because they think it is a worthy alternative to medical care. For their expectations to be met, the system must provide continuity of care throughout the reproductive cycle. Midwives must be enabled to provide counselling, education, and emotional support. Mechanisms must be developed to enable midwifery to respond to social change.

3. Autonomy

The experience in other countries demonstrates that midwifery care is most effective when midwives can practise autonomously through their full scope of practice and when midwifery is recognized as an independent profession.

Midwives must be permitted to take responsiblity for the management of their clients' care; they should not be used as extended role nurses or physicians' assistants.

4. Integration

Midwives must be fully integrated into the overall health care system if they are to provide safe and effective care. Student midwives should be educated in the same settings as medical and nursing students. Midwives and physicians must cooperate with each other in the care of individual women, and the two professions must collectively agree on such things as protocols for referrals and consultations.

5. Credibility

Midwives must gain the confidence of consumers, other health care providers, and hospital boards and administrators if they are to overcome their many years of isolation from the official health care system. No woman should be compelled to be cared for by a midwife instead of a physician, but the benefits of midwifery care should not be obscured by anxiety over its safety or confusion over the midwife's role.

6. Government Support

Even in the Netherlands, where midwifery is well established and midwives play a major role in the provision of maternity care, the government considers it necessary to support and protect the profession. Here in Ontario, where midwifery must be established anew, the government must commit itself to providing adequate funds for midwifery education and services and to enacting the legislation necessary to enable midwives to take their place in the health care system.

The Midwife's Scope of Practice

The Task Force recommends that Ontario enact a Midwives Act in which the midwife's scope of practice is defined consistently with the following international definition of midwife*:

> [The midwife] must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the mother. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the patients but also within the family and community. The work should involve antenatal education and preparation for parenthood, and extends to certain areas of gynaecology, family planning and child care.
>
> She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service.

*Adopted by the International Confederation of Midwives and the International Federation of Gynaecologists and Obstetricians; used by the World Health Organization.

The midwife's main functions are:

- monitoring normal pregnancies;
- identifying pregnancies at risk;
- counselling and educating the pregnant woman;
- caring for the woman and monitoring the condition of the foetus during labour;
- conducting spontaneous vaginal deliveries;
- examining and caring for the newborn infant;
- caring for and advising the woman during the postpartum period; and
- taking emergency measures when necessary.

The midwife is a specialist in "normal" reproductive care; her primary client group is women with healthy, low risk pregnancies who are expected to have uncomplicated deliveries. However, we believe that midwives should not be totally excluded from attending women whose care must be managed by physicians, for these women, too, can benefit from such components of midwifery care as counselling and teaching. Although in some countries midwives provide gynaecological care outside the reproductive cycle, no evidence was presented to the Task Force that there is a need for midwives to perform this function in Ontario.

The *Health Disciplines Act*, which regulates five disciplines, including medicine and nursing, provides a mechanism for delegating acts in the practice of medicine to non-physicians. We believe there are acts outside the scope of practice of midwifery that a midwife can usefully perform for a client even after a physician has assumed responsibility for care (such as regulating the amount of intravenous medication being used to stimulate labour); provision should therefore be made for delegating such medical acts to midwives. However, delegation should be used sparingly so that midwives do not gain competence in the use of medical technology at the expense of clinical midwifery skills.

In every jurisdiction we investigated, midwives' clients visit physicians at prescribed times during pregnancy. We believe that two medical visits are in the best interests of the pregnant woman and the foetus, the first to take place as early in pregnancy as possible, the second at 32 to 34 weeks. In addition to providing an assessment of the woman's health condition, of the status of the pregnancy, and of whether or not she should be cared for by a midwife, the visits will provide access to prescription medications and to tests and procedures for which a physician's authority is required. Midwives' standards of practice should provide criteria for additional consultations with and referrals to physicians; these should be developed by the governing body for midwives in consultation with the appropriate professional bodies.

The Framework of Practice

The Task Force believes that midwifery can be practised effectively in a variety of settings, including hospitals, birthing centres, medical practices, and private midwifery practices. No single model should be imposed on all communities or all midwives. The important thing is that every practice, however structured, exhibit the characteristics of safe and effective midwifery care. These are that:

- Continuity of care is provided;
- The midwife's responsibilities include counselling, education and emotional support;
- The midwife has access to both institutional and community settings;
- The midwife has arrangements with physicians for consultation and referral and for ordering medications, tests, and procedures;
- The midwife practises autonomously within her scope of practice;
- The midwife focusses on low risk pregnancies and normal childbirth;
- The midwife has an opportunity to engage in continuing education and peer review;
- The midwife's working conditions are reasonable and she is fairly paid;
- The practice is responsive to consumer needs and preferences;
- The practice continuously evaluates its effectiveness; and
- The care provided is cost-effective.

The Task Force recommends that an approval mechanism be created to ensure, as far as possible, that these characteristics are exhibited by every practice. Any institution, group or individual wishing to establish a midwifery service or practice will submit a proposal to the Ministry of Health. By granting or withholding approval, the Ministry can regulate the quality and effectiveness of midwifery care and can ensure that midwives are integrated into the health care system in a planned and orderly way.

However, program approval alone will be insufficient to establish a practice or service: funding is also required. In announcing the decision to recognize midwifery, the Minister of Health did not explicitly address whether midwifery services will be paid for by the province or by consumers. We agree with the view expressed in the overwhelming majority of submissions — that the province should pay for midwifery services. Identifying an appropriate payment mechanism for midwifery services proved to be difficult. We concluded that payment on a fee-for-service basis, as physicians' services are paid for under the Ontario Health Insurance Plan, would be inappropriate and impractical for midwives. Instead, we recommend that the Ministry of Health provide funding to approved midwifery practices and services on the basis of global program budgets.

In our opinion, midwives should not be permitted to charge their clients directly. Midwifery care should be equally accessible to all women; there should be no cadre of "elite" midwives catering to the minority of women who can afford to pay for their services themselves. While we recognize that Ministry funds allocated to midwifery services may be insufficient to support every practice that obtains program approval in a fiscal year, we believe the only exception to the principle of government funding should be to permit organizations such as unions, voluntary associations and charitable foundations to provide full or partial funding to approved practices.

More than 99 per cent of babies born in Ontario are delivered in hospitals. It is therefore impossible to integrate midwives into the health care system without allowing them access to hospital birthing facilities. If midwives cannot attend hospital births, their clients will be forced to choose between giving birth at home and giving birth in hospital with a caregiver (a physician) not of their choosing. Far from advancing the policy of encouraging women to give birth in hospital, excluding midwives from hospitals will encourage women to stay at home. It will also foster the development of a group of "home birth" midwives practising remotely from the overall health care system. We therefore recommend that the *Public Hospitals Act* and regulations be amended to empower hospitals to grant staff privileges to midwives.

Professional liability insurance is necessary to protect midwives and their clients against the consequences of mistakes made in the provision of care. Unfortunately, the integration of midwifery into the health care system comes at a time when the availability of professional liability insurance is restricted and premiums are high. The Task Force nevertheless believes that liability insurance should be mandatory for practising midwives; without it, midwives cannot be fully responsible for their actions, physicians will be reluctant to cooperate with them, and hospitals will not grant them staff privileges. Midwives employed by hospitals and other institutions will be covered by their employers' insurance, but those in private practice will have to purchase individual policies. Midwives should take steps through their professional association to develop a self-financed insurance program.

Home birth remains controversial in Ontario even though very few women choose it. The medical and nursing professions are virtually united in their opposition to planned home birth, while midwives believe that home is a safe birthing environment for properly selected women. Several recent reviews of the scientific literature on home birth have concluded that the evidence does not prove that home birth presents inordinate risks to all women and infants; indeed, there is some evidence that morbidity (illness) is greater among women and infants delivered and cared for in hospital. The Task Force believes that there can and should be a consensus among health care providers that all places of birth, including home, should be made as safe as possible. Home birth is made safer if only carefully selected women give birth at home and if these women are cared for by midwives or physicians. We recommend that the governing body for midwives, in consultation with medical experts, prepare a home birth protocol to guide midwives in assessing their clients' suitability for home birth. We suggest other ways of maximizing the safety of home birth within existing resources.

Qualifications for Practice

The appropriate entry requirements for the study of midwifery was a fundamental issue that faced the Task Force. On the one hand, nursing organizations and nursing educators proposed that every person who wishes to study midwifery should first be required to obtain an education in nursing; this model of entry would give the nursing profession a monopoly over midwifery. On the other hand, midwives, midwifery organizations, and most consumer organizations proposed that people without prior education in nursing should be permitted to study midwifery; this model of entry would permit nurses to train as midwives but it would also open midwifery to people with different educational backgrounds. We favour the second model, which we term "multiple routes of entry." We believe it is appropriate because midwifery is an autonomous profession, not a specialty of nursing, and because it will make the best use of educational resources and integrate existing midwives most effectively. Furthermore, it will prevent the creation of two midwifery professions: a regulated profession consisting of nurses and an unregulated "underground" profession consisting of non-nurse midwives.

We recommend a midwifery education program with two streams, to take advantage of the students' various educational backgrounds. A four-year stream, leading to a baccalaureate degree in midwifery, will provide comprehensive academic and clinical education to students with no prior relevant post-secondary education. A 12 to 18 month diploma stream will offer nurses with university level education an expeditious way of obtaining the additional preparation necessary for midwifery practice. The two streams must be integrated in a single program located at a university health sciences centre. That university should be selected by competitive tender. Wherever the program is located, access to it by Francophone students and by residents of Northern Ontario should be maximized through recognition of course credits obtained at other universities, decentralized clinical experience sites, and the Northern Ontario Distance Education Access Network. The program should use community hospitals, community health centres, and physicians' offices throughout Ontario for clinical education sites, both to provide student midwives with appropriate learning environments and to relieve pressure on tertiary care teaching hospitals.

Adequate funds must be allocated by the Ministry of Colleges and Universities and the Ministry of Health to establish the program on a firm basis and to enable it to offer a high standard of education. In particular, funds must be provided to compensate clinical supervisors and preceptors.

In addition to this university preparation, all who seek licensure in Ontario will be required to pass a comprehensive examination administered by the regulatory body.

Regulation of the Midwifery Profession

On April 3, 1986, the Minister of Health announced that midwifery will be a self-regulating profession. We considered whether the profession should be regulated, perhaps temporarily, by an experienced governing body, such as the College of Nurses. We concluded that it is preferable for a new governing body to be created to regulate the profession from the beginning. Initially, the Council of the governing body should consist of appointed experts and consumers; eventually, appointed experts should be replaced by midwives elected by members of the profession.

We believe midwifery should be regulated through a system of licensure, so that only those midwives who are registered by the governing body will be permitted to practise. To help consumers identify them, the titles "licensed midwife" and "midwife" should be restricted to their use.

Integration of Current Practitioners

The Task Force identified several groups of people with diverse midwifery qualifications who may wish to obtain licences to practise without completing the basic midwifery education program. These include approximately 50 midwives currently practising outside the official health care system and 900 or more nurses. Their midwifery knowledge, clinical skill, and experience should not be wasted. However, it is essential that no one be permitted to practise midwifery without first demonstrating their knowledge and clinical skill. We recommend that a Midwifery Integration Program be established. Applicants to the Program who obtain satisfactory scores in written and clinical examinations will be placed in hospitals, where their competence in providing all aspects of midwifery care will be assessed. Graduates of the Program will be given an opportunity to write the provincial midwifery licensing examination.

Since the Program should not be a substitute for basic midwifery education, it should be offered for a limited time. Midwives with formal midwifery qualifications obtained in other jurisdictions may present their credentials to the governing body for recognition. Provisional licences should not be issued to students in the Integration Program to authorize them to practise privately for its duration; however, women who wish to be cared for by students may "follow" them into the supervised setting of their clinical placements.

The Potential Requirement for Midwives

It is very difficult to estimate how many midwives Ontario will require; the potential requirement will depend on many factors, including policy decisions yet to be made. A key factor will be the amount of money the Ministry of Health allocates to midwifery services, and the impact of this allocation will be affected by midwives' productivity and how much they are paid. We have tried to estimate the numbers that might be required depending on how midwives are utilized.

We believe a reasonable objective is the formation of a pool of 50 qualified midwives within the first two years after implementation and a pool of 120 midwives at the end of five years. The education program should graduate a further 150 to 250 midwives by the year 2000, the number depending in part on how many foreign-trained midwives are licensed to practise in Ontario.

Improvements to Reproductive Care

Although the Task Force was not directed to consider how the overall system of reproductive care might be improved, we believe it is important to share what we have learned in the course of investigating how midwifery should be implemented. We believe the system can be improved at relatively little cost and with little disruption in the following ways:

1. Physicians, nurses and hospitals can pay greater attention to the psychological and social needs of childbearing women and their families.
2. Greater continuity of care can be provided.
3. Hospitals can permit greater flexibility in routines and protocols.
4. Hospitals can focus their efforts on improving care through people rather than decor.
5. Structures can be created to channel the views of consumers to hospital personnel in responsible positions.
6. In every hospital, one person can be assigned responsibility for effecting improvements.

7. Hospitals can establish forums for effective communication between medical and nursing staffs.

8. Resources both inside and outside hospitals can be used to obtain consistent high quality obstetrical care that responds to community needs.

9. The general practitioner's role in obstetrics can be strengthened and supported.

10. The defensive style of practice caused by fear of malpractice litigation can be moderated.

11. The nurse's role in providing family-centred maternity care can be strengthened.

12. The Ministry of Health can facilitate discussion of "good birthing" guidelines and issues in reproductive care.

SUMMARY OF RECOMMENDATIONS

Scope

1. The Task Force recommends that Ontario enact a Midwives Act in which the midwife's scope of practice is defined consistently with the international definition of midwife.

2. The Task Force recommends that the activities within the midwife's scope of practice relate primarily to the reproductive cycle.

3. The Task Force recommends that provision be made for the delegation of medical acts to midwives.

4. The Task Force recommends that the governing body for midwifery be vigilant to ensure that delegation of medical acts is used sparingly so that it does not produce more competence with technology at the expense of clinical skills.

5. The Task Force recommends that the standards of practice for midwives incorporate a minimum of two mandatory medical visits during pregnancy. We recommend that the first mandated visit be as early in the pregnancy as possible, and that the second be at 32 to 34 weeks.

6. The Task Force recommends that there be a third optional visit during the course of the pregnancy, at a time considered appropriate by the midwife, the physician involved in the case, or the woman herself. We recommend that additional medical visits, for which there is no actual need, be discouraged.

7. The Task Force recommends that the standards of practice for midwives include criteria for consultations with and referrals to physicians. We recommend that the governing body for midwives prepare these standards of practice in consultation with the College of Physicians and Surgeons of Ontario, the Society of Obstetricians and Gynaecologists of Canada and appropriate experts in the disciplines of medicine and midwifery. The standards should clearly differentiate between consultations for advice, consultations for advice and treatment, and transfers of care.

Framework of Practice

8. The Task Force recommends that all midwifery practices display the characteristics of safe and effective care.

9. The Task Force recommends that midwives work in hospital midwifery services that meet the requirements for safe and effective midwifery practice.

10. The Task Force recommends that midwives work in birthing centres that meet the requirements for safe and effective practice.

11. The Task Force recommends that the Ministry of Health expand the mandate of the Community Health Centre program to permit Community Health Centres to employ midwives, provided the requirements of safe and effective practice are met.

12. The Task Force recommends that midwives work in services sponsored by boards of health that meet the requirements for safe and effective midwifery practice.

13. The Task Force recommends that midwives work in private practices that meet the requirements for safe and effective midwifery practice.

14. The Task Force recommends that midwives and physicians work together in practices that meet the requirements for safe and effective midwifery practice.

15. The Task Force recommends that no midwife be permitted to practise except in a practice, service, agency or other health facility approved by the Ministry of Health.

16. The Task Force recommends that a mechanism be established in the Ministry of Health for approving all institutional and community-based midwifery practices and services. We recommend that proposals to establish such practices and services be evaluated by a designated operational branch in conjunction with the Women's Health Bureau of the Ministry, and that approval be granted to proposed practices and services that meet the requirements for safe and effective midwifery practice. We recommend that the Ministry be empowered to discontinue or cancel approval if a practice or service fails to provide safe and effective midwifery care after a reasonable opportunity has been provided for it to do so.

17. The Task Force recommends that the Ministry of Health provide funding to approved institutional and community-based midwifery practices and services, including those proposed by individual midwives, groups of midwives, multi-disciplinary groups, boards of health, community agencies, physicians and hospitals. We recommend that funding be provided on the basis of global program-based budgets.

18. The Task Force recommends that the Ministry of Health appoint a member of its staff to assist applicants in preparing and submitting applications for program approval and funding.

19. The Task Force recommends that midwives be prohibited from seeking or obtaining payment for midwifery services directly or indirectly from clients.

20. The Task Force recommends that midwives be permitted to charge fees for childbirth education classes.

21. The Task Force recommends that the Ministry of Health be empowered to permit organizations such as unions, voluntary associations, and charitable foundations to pro-

vide full or partial funding to approved midwifery practices and services.

22. The Task Force recommends that the *Public Hospitals Act* and Regulations be amended to empower hospitals to appoint midwives to the hospital staff.

23. The Task Force recommends that the *Public Hospitals Act* and the Regulations thereunder be amended to establish the necessary structures and procedures for appointing midwives to the staffs of hospitals.

24. The Task Force recommends that liability insurance be mandatory for practising midwives.

25. The Task Force recommends that midwives, through their professional association, take steps to develop a self-financed insurance program as soon as possible.

26. The Task Force recommends that the governing body for midwifery prepare a home birth protocol covering assessment of risk and contraindications to home birth. In preparing the protocol the governing body should consult with appropriate professional organizations and authorities.

27. The Task Force recommends that the governing body for midwifery develop a standard of practice and establish a practice advisory service to provide guidance to midwives with regard to the care of women who choose to give birth at home despite contraindications.

28. The Task Force recommends a flying squad network not be created in Ontario to support home births. We recommend that caregivers and parents take responsibility for ensuring that transportation will be available during labour if needed.

29. The Task Force recommends that the Ministry of Health establish a home birth registry for the reporting of the mortality and morbidity outcomes of all home births taking place in the province. The registry should elicit detailed information on the mother's risk status, whether the home birth was planned or unplanned, and the causes of morbidity and mortality.

Qualifications

30. The Task Force recommends that there be multiple routes of entry to midwifery education in Ontario.

31. The Task Force recommends that midwifery education be provided in a program with two integrated streams: a four-year stream leading to a baccalaureate degree in midwifery and, for people who have university-level preparation in nursing, a 12 to 18 month stream, leading to a diploma in midwifery.

32. The Task Force recommends that the baccalaureate and diploma streams be offered at the same educational institution, and that courses, teaching and clinical faculty, clinical placement sites and student activities be combined, shared and intermingled.

33. The Task Force recommends that midwifery education be based at a university.

34. The Task Force recommends that the midwifery program be located at one of Ontario's health sciences centres.

35. The Task Force recommends that the Northern Ontario Distance Education Access Network be used in order to make it possible for parts of the midwifery education program to be taken in Northern Ontario communities.

36. The Task Force recommends that clinical components of the programs be arranged in community hospitals and suitable primary health care settings in various locations in Ontario.

37. The Task Force recommends that the university not restrict admission, or give preferential admission to applicants who reside in the geographical area from which it ordinarily draws the majority of its students. We recommend that attention be paid to applicants' home communities in an effort to admit qualified applicants from every part of Ontario.

38. The Task Force recommends that academic courses and clinical placements in the French language be arranged on an individual basis for Francophone students and that all universities cooperate to permit this to be done.

39. The Task Force recommends that the Ministry of Colleges and Universities select a centre through a competitive tendering process open to all health sciences centres. We recommend that the criteria used in assessing the proposals relate to the recommendations set out in this chapter, including use of the Northern Ontario Distance Education Access Network, use of other universities for French language instruction, use of clinical education sites in hospitals and primary care locations throughout Ontario, and existence of structures for contacts between midwifery, nursing and medical faculties, and students.

40. The Task Force recommends that selection of students not be based solely on academic achievement and that procedures used include assessment of applicants' personal suitability for midwifery, including their maturity, motivation, resourcefulness, service orientation and ability to relate to others.

41. The Task Force recommends that admission to the baccalaureate program be considered for students who can demonstrate that their life experience (including work, homemaking, childrearing, and volunteer activities) qualifies them for entry.

42. The Task Force recommends that advanced standing and course remission be available to students in the midwifery program.

43. The Task Force recommends that the baccalaureate curriculum be structured to complement the emerging "two plus two" structure of the baccalaureate nursing program. We recommend that humanities, social sciences, basic sciences and health sciences subjects be concentrated in the first two years, and that midwifery practice subjects be concentrated in the second two years. We recommend that where possible courses be shared with students in other health disciplines such as nursing and physiotherapy.

44. The Task Force recommends that courses be shared with students in the third and fourth years of the baccalaureate stream, and that the clinical placements for diploma students be indistinguishable from clinical placements for baccalaureate students (except the latter will require clinical practice in additional areas of nursing skills).

45. The Task Force recommends that community hospitals with Level I and Level II obstetrical services, community health centres, and physicians' offices in various parts of Ontario be used to provide clinical placement sites.

46. The Task Force recommends that the Ministry of Colleges and Universities or the Ministry of Health make funds available to compensate clinical instructors and supervisors of student midwives.

47. The Task Force recommends that the education program actively seek clinical elective opportunities in other jurisdictions and assist students who wish to take advantage of them.

48. The Task Force recommends that requirements for graduation include numbers of clinical experiences, including examinations, supervision and care of pregnant women, deliveries, postpartum examinations and newborn examinations. We recommend that the requirements be the same for students in both the diploma and the baccalaureate stream.

49. The Task Force recommends that funds be allocated for the establishment of midwifery education programs, and that the amount of start-up funds reflects the costs of curriculum design, faculty requirement and arrangements for clinical placement and supervision, as well as necessary capital improvements such as additional classroom space. We recommend that adequate operating grants also be made available.

Regulation

50. The Task Force recommends that midwifery be regulated through a system of licensure.

51. The Task Force recommends that the titles "midwife" and "licensed midwife" be protected titles for the profession of midwifery.

52. The Task Force recommends that a new governing body, a College of Midwives, be established to regulate the profession of midwifery.

53. The Task Force recommends that the Lieutenant Governor in Council appoint 13 members to serve on the Council of the College of Midwives at pleasure.

54. The Task Force recommends that representatives be selected from among students in the Midwifery Integration Program and foreign-trained midwives waiting to present their credentials for recognition, to provide liaison and advice to the interim Council.

55. The Task Force recommends that three midwives be appointed to the Council as soon as possible, selected from among the midwives licensed after successfully completing the Midwifery Integration Program and foreign-trained midwives whose credentials obtained are recognized. We recommend that the number of places on the Council allocated to midwives gradually increase thereafter to a maximum two-thirds of the total number of places. We recommend that the midwives appointed to the Council replace representatives of other disciplines rather than consumers. We further recommend that midwives be elected to the Council, rather than appointed, as soon as their numbers warrant.

56. The Task Force recommends that in the long run the permanent Council of the College of Midwives be composed of between nine and 15 members elected by licensed midwives; between three and five public members appointed by the Lieutenant Governor in Council; and one person appointed by the university that administers the midwifery education program.

57. The Task Force recommends that the Council be required to constitute an Executive Committee, as well as committees responsible for Registration, Fitness to Practise, Continuing Competence Assurance, Complaints, and Discipline.

58. The Task Force recommends that the College of Midwives share administrative services, office facilities, and staff with one or more governing bodies of unrelated health professions.

59. The Task Force recommends that the College of Midwives establish criteria for recognizing the qualifications of foreign-educated midwives. We recommend that the criteria relate to the equivalence of educational preparation, and the recency and relevancy of practice experience.

60. The Task Force recommends that the College of Midwives set and administer an examination for all midwives who wish to be licensed to practise in Ontario.

61. The Task Force recommends that the College of Midwives, through the Continuing Competence Assurance Committee, establish systems for assuring continuing competence.

62. The Task Force recommends that the College of Midwives be empowered to prosecute people who contravene midwifery legislation.

63. The Task Force recommends that the Ministry of Health subsidize the establishment and ongoing operation of the College of Midwives until the profession has sufficient numbers to bear the full costs of College operations.

Integration

64. The Task Force recommends that a Midwifery Integration Program be established for the purpose of integrating people into the profession of midwifery.

65. The Task Force recommends that the Integration Program be administered by the same educational institution that will administer the basic midwifery education program.

66. The Task Force recommends that adequate funding be provided to the Midwifery Education Program by the Ministry of Health and Ministry of Colleges and Universities.

67. The Task Force recommends that the Midwifery Integration Program be offered for a limited time.

68. The Task Force recommends that provisional licences not be issued to students in the Midwifery Integration Program to authorize them to practise midwifery outside the Program.

Potential Requirement

69. The Task Force recommends that the Ministry of Health and the Ministry of Colleges and Universities coordinate human resources planning for midwifery, nursing and medicine.

70. The Task Force recommends that nursing, medical, and midwifery bodies that address human resources planning in submissions to government consider the role played by the other professions in providing maternal and infant care.

Preface

During the course of our work, we have been privileged to share with scores of parents the warm recollections and private agonies of their childbirth experience. Their stories have shown us the depth of emotion that attends pregnancy and childbirth.

For many, pregnancy and birth are among the most intimate and moving experiences in their family life. The childbearing year is a time when family members explore and deepen the affection they have for one another. A woman and her partner encounter in themselves and in each other emotional resonances that are rich and unexpected. Grandparents, siblings and special friends are enlivened by the new closeness and delight that a baby brings.

Yet not everyone experiences childbirth joyfully. Because of the heightened emotions felt during pregnancy and childbirth, trouble when it comes strikes hard. Miscarriage, stillbirth, infant death and abnormality bring grief and confusion. Of course, they always have but we are somehow less prepared for them now than we once were. Such is our vulnerability in an era that expects "perfect obstetric outcomes." Fear and loneliness are the attendants of women who give birth far from their families or from familiar cultures, or without sustaining companions in labour. Even when tragedy and isolation can be kept at bay, parents may still feel dehumanized in institutional settings.

A strong theme in the presentations to the Task Force has been the need to recognize the emotional and familial significance of childbirth, to think of the birth of a baby not just in medical terms, but in human terms too. The parents who spoke and wrote of this need told us of the crucial role, for good or ill, played by those who attend them in pregnancy and delivery. For these parents, as for all parents, the birth of their child is a unique experience. For the professionals who care for them, pregnancy and birth are everyday occurrences. The challenge caregivers face is to respect each parent's sense of the importance and singularity of the birth experience, while at the same time to bring to their work the knowledge accumulated at hundreds of births. For the most part, they meet the challenge well: they practise with warmth and good humour and with a skill that has given Ontario perinatal outcome rates that rank among the best in the world.

The search by parents and caring professionals for new ways to combine skill and humanity in the birth experience contributed to the decisions to legalize midwifery in Ontario and to establish our Task Force. This search is not an isolated phenomenon. In many countries, there is debate about the use of technology in birth. People in many developed countries fear that we are abandoning too much of our traditional wisdom about childbirth. These concerns of practitioners and clients echo and are reinforced by voices in the women's movement who claim that Western culture has systematically undervalued the female perspective and assaulted women's integrity in the birth process.

We are pleased to have had the opportunity to become acquainted with some of the most significant thinkers involved in this important debate and to meet with many thoughtful professionals exploring these questions on a daily and very immediate basis. We hope that this Report will help in the quest for a better balance between traditional knowledge and technological innovation. We hope too that our recommendations meet the expectations of those in Ontario who also seek such a balance.

To the extent that we have succeeded, our thanks are due to a number of people. Any shortcomings in our Report are, of course, our own responsibility.

We thank the hundreds of people who worked hard to prepare submissions and to come to our public hearings. We are especially grateful to the members of the health care and hospital communities in Ontario and elsewhere who spent countless hours sharing their perspectives and expertise with us during our study tours and consultations. Such goodwill augurs well for the future of pregnancy and childbirth care.

To the Ministers of Health and Colleges and Universities go our thanks for their insight, accessibility and support. To the government officials who provided information and advice goes our appreciation. Although there are many officials in Ontario who eased our task, we offer special thanks to the Deputy Ministers and Assistant Deputy Ministers of Health and of Colleges and Universities, who have opened many doors for us; and to Paul Gardner, Dr. Roch Khazen and Sheila Latimer of the Ministry of Health and Elaine Hykawy of the Ministry of Colleges and Universities for their helpfulness.

The Task Force has had the benefit of excellent staff, without whose efforts we would have been unable to accomplish our task. Linda Bohnen became our Executive Director very soon after the Task Force was appointed. She organized our research effort and assumed the major responsibility of preparing the report. She has played a pivotal role in our work with insight, talent and humour. We thank her most warmly. Hildy Abrams, seconded to the Task Force from the Ministry of Health, has brought great enthusiasm and skill to her role as Manager of Administration. She has given us unflagging support, and a welcome boost of energy to complete our work. Jutta Mason opened up for us the history of midwifery in Canada, sharing years of research; Kate Hughes worked tirelessly to prepare us for the public hearings and to summarize the hundreds of briefs we received. Our bibliographer, Wong Yuk Yin, and Dagmar Horsburgh who scheduled our travel and public hearings, have worked painstakingly on essential details. The Task Force has also benefitted from the generosity of Professor Jonathan Lomas from McMaster University and Daphne Wagner of the Health Professions Legislation Review, who shared their expertise with us. Greg Ioannou saw us competently and cheerfully through the editorial process and Julie Cordwell steadfastly typed our voluminous manuscript.

The Task Force would like to record its gratitude to those who made it possible for us to undertake the responsibilities of the past year and a half. Colleagues and staff in our own offices assumed extra responsibilities and bore the inconvenience of our meeting schedules. Clients, patients and students were called upon for extra forbearance. To all of them we are grateful.

Special appreciation goes to our spouses for support which allowed us to sustain the long hours and absences from home necessary to complete our study. More fundamentally, we acknowledge how much the lives we share with them have helped us understand the importance of our present work to other families.

And now a final word.

Task Force members and executive staff are parents to twelve wonderful children, ranging in age from a baby born during the summer of 1986 to a daughter at university. They came into our families in many different ways: midwife, GP, and obstetrician attended births; adoption, vaginal birth, and C-section. At least two owe their lives to the kind of high-tech intervention we heard so much about at our hearings. One Task Force member cherishes relationships with stepchildren and their families. To all of these children this Report is particularly dedicated. They continue to teach us about the human heart, and about how much can be accomplished with love and hope.

Mary Eberts
Toronto, Ontario
July, 1987

Chapter 1

INTRODUCTION

Appointment of the Task Force

On January 23, 1986, the Honourable Murray Elston, the Ontario Minister of Health, announced the government's intention "to establish midwifery as a recognized part of the Ontario health care system" and that midwifery would become a regulated health profession. He announced the creation of a Task Force on the Implementation of Midwifery in Ontario, to recommend to him and to the Honourable Greg Sorbara, Minister of Colleges and Universities, a framework for the practice and education of midwives.

The terms of reference of the Task Force were as follows:

> The Task Force on the Implementation of Midwifery in Ontario will provide advice to the Minister of Health on matters of particular interest to him within the areas of education of midwives, requirements for entry to practice, scope and standards of practice, governance of the profession, locations of practice, patient access and whether midwives should operate as independent practitioners or as part of an organized service. Specifically the Task Force will:
>
> - develop a policy framework on how midwifery should be practised in Ontario;
> - recommend how midwives should be educated;
> - recommend requirements for entry to practice, scope and standards of practice, governance of the profession;
> - recommend whether midwives should operate as independent practitioners or as part of an organized service;
> - recommend in what setting midwives will provide their services; and
> - recommend optimal relationships between midwives and physicians.

The decision to establish the Task Force was based on a recommendation made to the Minister of Health by the Health Professions Legislation Review that the government take steps toward the regulation of midwifery in Ontario. The Review was officially established in 1983 to recommend to the Minister which health care professions should be regulated, and to devise a statutory framework for their regulation. The Review received submissions from 150 groups, including 75 health professions, as well as unions, consumer organizations, and health care institutions. Many groups made several submissions, in response to presentations made by other groups and to questions asked by the Review. Three submissions were made by the Ontario Association of Midwives and the Ontario Nurse-Midwives' Association, the two organizations then representing midwives in Ontario. Working together as the Midwives' Coalition, they urged the government to accept midwifery as a regulated profession, and put forward detailed proposals for its regulation.

For several years, interest in midwifery had been growing among various groups in Ontario. The interest was developing largely but not exclusively among women, who believed that maternity care was overly controlled by the obstetrical profession — mostly male doctors who were thought to regard pregnancy and childbirth as pathological events and to be insufficiently attuned to the psychological and social needs of childbearing families. These consumers believed that midwives, by virtue of their education, their philosophy and perhaps their sex, were better able to provide holistic maternity care in which pregnancy and childbirth were regarded as normal physiological events and medical interventions such as episiotomy and caesarean section were minimized. Such beliefs were leading to a renascence of interest in midwifery across North America, and a rethinking of maternity care in much of the developed world.

At the same time, the number of midwives practising in Ontario was growing. Although they practised without official sanction, and their numbers remained comparatively small, the midwives were increasingly effective in communicating their case for recognition to government and to the public.

The Ontario Nurse-Midwives' Association had been formed in 1973 by a group of registered nurses as an interest group within the Registered Nurses' Association of Ontario. Most of them had obtained formal midwifery education outside Canada, primarily in Britain. They believed that the fragmentation of maternity care and the routine use of operative procedures were hazardous to mother and child. The Association lobbied within the larger organization to achieve recognition for midwifery, consciously focussing its efforts on other nurses, rather than on the general public and government. Its members felt that American nurse-midwifery was a useful model, which could enable midwifery to gain recognition in Ontario and might eventually lead to professional autonomy.

In 1979, a group of midwives formed the Ontario Association of Midwives. Some of its members had been educated at midwifery schools in other jurisdictions that admit students with no prior nursing education. The majority had learned their profession by a combination of self-teaching, apprenticing to other midwives, and accompanying physicians to home births. In spite of these different levels in formal education all considered themselves to be professional midwives.

Both associations were affected by several outside events. In 1982 an inquest was conducted into the death in Kitchener, Ontario, of an infant whose birth involved a midwife. The Ontario Association of Midwives retained a prominent lawyer to represent it at the inquest. The jury recommended that the College of Physicians and Surgeons and the College of Nurses set up standards for midwives and establish a program of study in midwifery leading to licensing in Ontario. The inquest rallied and politicized the midwives, who realized that they needed to articulate standards of practice and education for themselves and become more sophisticated in their dealings with the public.

In 1983, the College of Physicians and Surgeons of Ontario (CPSO), the governing body of the medical profession, issued a statement to its members about home birth. Although the statement did not expressly forbid physicians to participate in home births, it expressed strong disapproval of home birth on the grounds of safety. As a result of the statement, most of the physicians who had been attending home births in Ontario stopped doing so and patterns of midwifery practice changed accordingly. Until that point, most midwives in Ontario were accompanied at home births by physicians. Interestingly, however, the impact of the CPSO statement on the midwifery community was mitigated by a small influx into Ontario at about this time of foreign-educated midwives and midwives who had practised in jurisdictions where they had not collaborated with physicians. A few midwives now stopped attending women at home, but most continued to do so unaccompanied by physicians. Some women who would have preferred to give birth at home with both physician and midwife in attendance changed their plans and either gave birth at home with only a midwife in attendance, or went into hospital where they were delivered by a physician and their midwife might be permitted to attend as labour coach. Overall, and in addition to its impact on patterns of midwifery practice, the CPSO statement further politicized the midwives and in the opinion of their Association increased their self-confidence as independent practitioners.

In November 1984, the Ontario Nurse-Midwives' Association and the Association of Ontario Midwives officially merged under the name Association of Ontario Midwives. The work the associations did for the Review had paved the way for the merger. Because it was felt that the Association of Ontario Midwives, as the midwives' professional association, should not have consumers and members of other health professions in its membership, the Midwifery Task Force was formed at the same time. Organized into local chapters across Ontario, it serves as a support group for midwives, lobbying for official recognition of midwifery, raising funds, and publishing a newsletter. Despite the similarity in names, the Midwifery Task Force and this Task Force are completely separate bodies.

During 1983 and 1984 the midwives pressed their case for recognition with members of the Ontario Legislature. Partly as a result of their efforts, Dave Cooke, a New Democratic Party MPP, introduced a Private Member's Bill to establish midwifery as a self-governing health profession under the *Health Disciplines Act*. Mr. Cooke moved second reading of the Bill on November 1, 1984. The Bill was opposed by some members of the Legislature and no vote was taken on it.

Midwifery is Catching, a popular book by Eleanor Barrington about midwifery and its status in Canada, was published in Toronto in 1985. The author was an active member of the Midwifery Task Force. The book buttressed its argument for legal recognition of midwifery with accounts of childbirth experiences involving midwives, and photographs of midwives helping women in childbirth.

In the spring and summer of 1985, a less auspicious event focussed public attention on midwifery and on the separate issue of home birth. In October 1984, a baby boy died in hospital two days after his birth on Toronto Island. His mother's labour had been prolonged, and she and the baby had been transported to hospital in downtown Toronto following his birth. An inquest was ordered by the Regional Coroner for Metropolitan Toronto and Central Region, Dr. James G. Young, after an investigation by his office only partially answered several questions about the death. Dr. Young was also aware of the campaign to obtain official recognition for midwifery and the fact that midwives, though unrecognized, were still delivering babies in Ontario. He felt that an inquest would clarify the causes of the infant death, and provide a forum for discussion of the desirability and safety of midwifery and home birth. The inquest was extensively reported in the news media. Numerous expert witnesses were called to give evidence by the coroner and on behalf of the midwives and the baby's parents.

The jury concluded that death resulted from the baby being deprived of oxygen during labour and birth, and that the baby would have survived if the mother had been transported to hospital sooner, where the foetal heart would have been electronically monitored and sophisticated resuscitation equipment employed. The jury recommended that midwifery be legally recognized in Ontario and incorporated into the health care system. It stated that, initially, midwifery should be governed as a specialty within the College of Nurses of Ontario, and that after five years, a College of Midwives should be established. The College should establish standards of practice in accordance with internationally recognized standards and practices. The jury recommended that an educational program for midwifery be established in accordance with the international standard of midwifery training and that there be a comprehensive licensing examination. Malpractice insurance should be compulsory. A method was proposed for permitting existing qualified midwives to be licensed. The jury also stated that midwives should be given admitting privileges and standing in hospital maternity wards, and midwifery services should be covered, at least partially, by the Ontario Health Insurance Plan. A second series of recommendations proposed improvements in the safety of home birth and the maternity care environment generally.

Although the jury concluded that death had been preventable, the Association of Ontario Midwives regarded the recommendations as an endorsement of midwifery and of the desirability of better integrating it into the health care system.

The Wider Context

Although it was against the background of these local events that this Task Force was created, the movement to recognize midwifery in Ontario has a wider context. It has to do with re-establishing a traditionally female occupation[1] that developments in medicine and medical technology threatened to extinguish. More fundamentally it has to do with changes in how society views childbirth itself.

In every culture women were the traditional birth attendants. In Europe, midwifery was practised exclusively by women until about the 18th century. However, its history before then was not untroubled, and midwives never secured for themselves a firm monopoly over childbirth in the way that barber-surgeons, for example, were able to monopolize their occupation through the guild system (Ehrenreich and English, 1973, 1978; Donnison, 1977; Kalisch, 1981).

In 18th century Europe, male physicians began to compete with midwives. At first, it was customary for a midwife to call in a physician only when complications set in and the baby could not be delivered. Physicians then began to perform the role of the midwife in normal cases, especially among the upper classes for whom having a "male midwife" or "male accoucheur" became fashionable. The one technical advantage physicians could offer was use of the obstetrical forceps; used skillfully, these could ease and hasten a difficult vaginal delivery.[2] As physicians became the preferred birth attendants of the upper classes, midwives came to be associated more and more with the lower classes. Midwifery became a less desirable occupation for women, especially educated middle-class women. In the 19th century, Charles Dickens' characterization of Sairey Gamp portrayed the English midwife as ignorant, unkempt and addicted to gin (*Martin Chuzzlewitt*).

When European women emigrated to North America they brought their childbirth customs with them. Midwives were the main birth attendants in the early British colonies along the Eastern seaboard, as well as in New France. However, although some of these early midwives achieved considerable prestige in their communities, North American midwives began to be edged out when physicians became interested in obstetrical practice (Donegan, 1978; Scholten, 1984; Wertz and Wertz, 1979).

In Canada even more than the United States, the emergence of the modern medical profession largely precluded the development of any real profession of midwifery. The traditional practice of midwifery by women was suppressed. This fact of Canadian history is important for an understanding of why midwives are almost unknown in this country (Anisef and Basson, 1979).

In Canada and the United States the modern medical profession emerged during the 19th century. Doctors practising like the physicians of today were known then as Regular, Allopathic or Orthodox practitioners. They were just one of several medical sects.[3] In the United States these Regulars had sufficient influence and connections to establish schools. Formal schooling gave them a "mystique of science", if not superior knowledge and technical skill, and this, together with their social and economic status, helped them secure a monopoly over medical practice through licensing laws (Ehrenreich and English, 1979).

In Canada, the pattern of settlement strongly affected the development of the medical profession — and the submergence of midwifery. In all but a few places the population was small and widely scattered. In those early days it was difficult to earn a good living practising medicine, and the inherent difficulties seemed to be compounded by competition from irregular practitioners — and midwives (MacNab, 1970; Hamowy, 1984).

The first statute to control medical practice in Upper Canada (Ontario) was the *Act to Regulate The Practice of Physic and Surgery* enacted in 1795. It imposed a penalty on any person practising physic or surgery in Ontario without approval from a Board of Surgeons. It exempted anyone not practising for profit, anyone in the military, anyone with a university degree and anyone who had practised surgery, physic or midwifery before the passing of the Act. Although the Act did not expressly exempt "female midwives", as did some later acts, they came under the exemption for currently practising practitioners. The Act was repealed in 1806 and replacement bills introduced in 1808, 1815 and 1819 were either defeated or repealed because of their impracticality (Caniff, 1894; MacNab, 1970).

In 1827, an act was passed with a stiff penalty (25 pounds or six months imprisonment) for unauthorized practice. This act expressly exempted female midwives. Physicians pressed the Legislature to delete the exemption and achieved success in 1839 with the enactment of a law that required any practitioner of medicine or midwifery to be a member of the College of Physicians and Surgeons. This act was quickly repealed and the Act of 1827, which exempted female midwives, remained in force until 1865.

In that year a *Medical Act* was passed that abolished the exemption for female midwives and prohibited them (and other unregistered practitioners) from recovering their fees in any court of law. In 1869 midwives were prohibited from practising for hire or gain, and the prohibition was strengthened in 1874. These prohibitions and the prosecution of unregistered practitioners were not widely supported by the public (Hamowy, 1984). *The Globe*, which opposed a medical monopoly, editorialized:

> In no way does the restriction imposed by the Medical Act operate more harshly and unreasonably than in imposing the terms of the law between women and the assistance they are accustomed to rely upon from members of their own sex...(September 11, 1875)

In neither the United States nor Canada did licensing medical practice put an immediate stop to midwifery (Leavitt, 1984; Litoff, 1978; Biggs, 1983). In both countries, female midwives continued to attend women in childbirth when there were no physicians to be had. In the United States, the clients were poor women living in urban slums and rural backwoods. In Canada, poor women and women living in areas not served by physicians continued to use midwives. Yet, as Jutta Mason describes in her historical account of Canadian midwifery (Appendix 1), to call these practitioners midwives is to put a false cast on our history. Most of them attended a very small number of births in a year, and they had no consciousness of practising a profession. Mostly, they were helping their friends and neighbours in their time of need, just as other women would help them when their time came. The help that they gave and received was as much to keep the household running — the family fed and clothed, the children tended — as it was to help the woman deliver her baby safely.

What happened to midwifery during the 20th century was different in the United Kingdom, the United States and Canada (Anisef and Basson, 1979). In Britain, criticism of the standard of midwifery practice led to proposals for education and legislation. These culminated in the institutionalization of midwifery with the enactment of the *Midwives Act* of 1902. Many midwifery schools were established, and midwives came to play an integral role in the British health care system. Nevertheless, while the institutionalized profession of midwifery is secure in the U.K., the role actually performed by most midwives has been eroded. Much of the professional autonomy — the exercise of clinical judgment in the management of women in pregnancy and childbirth — that midwives have in theory has, in practice, been relinquished to physicians. So too, they have lost the opportunity to provide the continuity of care that characterized their work in its early days. Only very recently have midwives in the U.K. sought to reclaim what they consider to be their rightful place in the system (RCM Report, 1987).

In the United States, the midwives who practised among immigrant women, black women and the poor never coalesced into a true profession. Infant and maternal mortality rates that were unacceptable to public health reformers during the first decades of the century were attributed to these so-called "granny midwives". Licensing laws in some states imposed unattainable educational requirements on midwives. Using a midwife came to be seen as "un-American" and benighted. The hospitalization of childbirth, and the emergence of the specialty of obstetrics, sealed the fate of the granny midwife. She continues to exist, but only at the margins of society (Leavitt, 1984; Litoff, 1978).

But the 20th century also saw the development in the United States of nurse-midwifery. Initially, it linked the professional practice of midwifery, in the British mode, to public health nursing among the poor. Nurse-midwifery has continued to play an important role in providing reproductive care to women who cannot afford physicians, but it has as yet failed to carve out a significant role for itself in serving mainstream American women.

Midwives have had less of a presence in Canada. Neighbour or granny midwives persisted longest in regions where physicians and hospitals came latest. Nurses with midwifery training were employed by organizations like the Canadian Red Cross to provide care to women in remote areas, a role performed to this day by nurses employed by the federal government in the far North. However, the care these nurses have provided in childbirth (as opposed to during pregnancy and after birth) has received little official recognition, and the full scope and extent of their work is probably still unknown. A unique Canadian initiative, originated by Lady Aberdeen and the National Council of Women in 1897, was to develop the Victorian Order of Home Helpers to train neighbourhood women to assist in childbirth and postpartum care. This initiative, like the development of nurse-midwifery, was defeated by nursing organizations that were hostile to the idea of incorporating midwifery (Buckley, 1979), a powerful medical profession that jealously guarded its territory, a relative lack of private philanthropy that might have financed such an endeavour, and the isolation of nurses providing midwifery care.

Having surveyed the history of midwifery, it must be said that on a more fundamental level, the changes in the status of midwifery are related to changes in the way society views birth itself. Anthropology teaches us that childbirth is a cultural phenomenon, as well as a physiological act (Romalis, 1981; Mead and Newton, 1967; Montagu, 1978; Haire, 1981). How birth is treated in any society is a product of its culture, ideology, norms and expectations.

The more childbirth is seen as a healthy event in the natural cycle of life, the more are midwives valued as birth attendants. The more birth is seen as a potentially pathological event, the more midwives have given way to physicians, especially obstetricians. The change in the way childbirth is viewed has affected the nature of midwifery practice even in countries where the profession of midwifery is apparently secure. Midwives have tended to become physicians' assistants, and have themselves come to rely more on obstetrical technology than on traditional ways of monitoring the progress of childbirth. It is perhaps not surprising that midwifery has been devalued most in North America, where the faith in medical science and technology is perhaps strongest.

The transformation of birth into a medical event deserving of ever more sophisticated technology has been premised on the belief that "medicalized" birth is birth improved. The thrusts during the first few decades of the twentieth century — to move all births into hospital, to mobilize public health nurses to take prenatal care to every pregnant woman, to have every woman attended in childbirth by a physician — were driven by the belief that medical attention and hospitalized birth would lead to fewer infant and maternal deaths, and healthier mothers and babies (Biggs, 1983).

The mortality statistics available at the time, which did not support this belief, were largely explained away.[1] Hospitalization of birth continued apace notwithstanding markedly higher mortality rates in hospitals. Medical procedures, such as the use of forceps, were increasingly resorted to during labour and birth; this trend was nicknamed "meddlesome midwifery." The reservations expressed about it in some quarters of the Canadian medical community from the end of the 19th century through the 1930s were to little effect. The 20th century mood was intent on improving childbirth, by easing its pain through chloroform, "twilight sleep", and later more sophisticated methods of analgesia, by developing the tests to detect abnormalities and complications of pregnancy, and by inventing the technology to save smaller and smaller newborns.

No sensible person minimizes the benefits of these medical advances in saving the lives of mothers and babies who would otherwise have died. Maternal deaths are now considered preventable tragedies. The modern expectation is that every pregnancy will result in a healthy, perfect baby.

Yet the renascence of midwifery is related to the feeling that something valuable has nearly been lost in these medical advances. Different people focus on different things. Some people point to our high rates of caesarean section and forceps delivery. Some point to inflexible, insensitive hospital policies that, for no demonstrably good reason, assault women's dignity, deprive them of the comfort of their families and friends, and disrupt the forging of bonds between mothers and newborns. Others point to the lack of attention paid to women's psychological and social needs during pregnancy and the postpartum period.

In her novel *Surfacing* Margaret Atwood describes the modern experience of childbirth in a way that its critics will immediately understand:

> After the first, I didn't ever want to have another child, it was too much to go through for nothing, they shut you in a hospital, they shave the hair off you and tie your hands down, and don't let you see, they don't want you to understand, they want you to believe that it's their power, not yours. They stick needles in you so you won't hear anything, you might as well be a dead pig, your legs are up in a metal frame, they bend over you, technicians, mechanics, butchers, students clumsy or sniggering, practising on your body, they take the baby out with a fork like a pickle out of pickle jar. After that they fill your veins up with red plastic, I saw it running down the tube. I won't let them do that to me ever again.

In essence, the critics of the existing system (providers of care as well as consumers, together with organizations like the Canadian Institute of Child Health) seek to reclaim birth, to restore the things that were of value in the traditional way of birth. They ask what the benefit high technology can be to healthy women with uncomplicated pregnancies. One commonly used descriptive term for what they seek is "family-centred maternity care". They want improved hospital practices, greater continuity in care so that being pregnant and having a baby are less like travelling down an assembly line, and greater choice in where to give birth through birthing centres and birthing rooms. And they want greater choice in caregivers through the recognition of midwifery.

The Work of the Task Force

The Task Force gathered information about how midwifery is practised outside and inside Canada, how Ontario midwives and other health care providers envision midwifery care being integrated into the health care system, and how the public perceives its needs.

With the assistance of the Library of the Ministry of Health, the College of Nurses of Ontario, the Association of Ontario Midwives and other groups and individuals, we assembled an extensive collection of books, journal articles and papers on midwifery and selected aspects of reproductive care, including material on such topics as midwifery services in other jurisdictions, the sociology of the demand for midwifery services, the law relating to midwifery, ethical issues in childbirth, place of birth, and human resources planning. Our collection of journal articles and papers was made accessible to members of the public, who were free to read them in a reading area in our office.

The Task Force initiated a series of consultations with organizations representing key groups of health care providers, both to obtain information and to invite their input into the Task Force process. Within our first month we had met with representatives of the College of Nurses of Ontario, the Registered Nurses' Association of Ontario, the Association of Ontario Midwives, the Ontario section of the College of Family Physicians of Canada, the Ontario Medical Association, the Ontario Hospital Association, the College of Physicians and Surgeons of Ontario, and the Ontario section of the Society of Obstetricians and Gynaecologists of Canada. During this initial set of consultations we asked each organization about its position on midwifery, including the advantages it thought midwifery care might bring to the overall maternity system. We discussed overlaps between the practice of midwifery, family medicine, obstetrics, gynaecology, paediatrics and nursing; midwifery education; places of practice; costs; and professional liability. We asked each organization what it considered to be the major obstacles to implementing midwifery in Ontario.

As our work progressed, we frequently returned to representatives of these groups for further consultations and to obtain additional information. We also embarked on consultations with representatives of many other organizations and institutions, including the University of Toronto, University of Western Ontario, McMaster University, University of Ottawa, Queen's University and Laurentian University; the Heads of Health Sciences at Colleges of Applied Arts and Technology; the Ontario Region, Canadian Association of University Schools of Nursing; the Perinatal Outreach Program of Southwestern Ontario; and the General Practice, Hospitals, and Reproductive Care Committees of the Ontario Medical Association. The RNAO arranged for us to meet with representatives of many professional associations and interest groups within nursing.

Members of the Task Force were invited to make presentations about our work at a conference held by the Ontario Hospital Association, to the London and Toronto chapters of the Registered Nurses' Association of Ontario, at a symposium on midwifery sponsored by the University of Toronto at St. Michael's Hospital, and at a midwifery forum at the Ontario Science Centre. We visited hospitals in Thunder Bay, Metropolitan Toronto, London, Brantford and Ottawa that had expressed interest in employing midwives or providing clinical teaching sites for midwifery students, as well as the City of Toronto Department of Public Health, and a downtown Toronto community health centre. Some of us spent half a day at the Midwives Collective of Toronto where the midwives' clients kindly permitted us to sit in on their appointments.

To ensure that we obtained the views of the important institutions that may be affected by the implementation of midwifery, we invited submissions from every Ontario public hospital, university and college of applied arts and technology and from the Ontario Region of the Canadian Association of University Schools of Nursing, the Heads of Health Sciences at Colleges of Applied Arts and Technology and the Council of Ontario Faculties of Medicine. We also wrote to the 26 district health councils established in Ontario to identify local health needs, establish priorities and plan health care programs for their districts. Many of the district health councils were able to tell us about their reproductive care priorities and the local interest in midwifery.

To obtain the views of health care consumers we wrote to approximately 100 organizations, introducing ourselves and inviting submissions. The organizations included women's clubs and auxiliaries, feminist groups, various women's issues advisory committees, unions, social service agencies, and native, Francophone and multicultural organizations.

Hearings held across Ontario in October and November 1986 were important forums for obtaining the views of both the public and health care providers affected by the implementation of midwifery. Any group or individual who had made a written submission to the Task Force was given an opportunity to make an oral presentation and to answer questions. Hearings were held for six days in Toronto, and for one day in each of Ottawa, Thunder Bay, Dryden, London, Hamilton, Windsor, Sudbury and Kingston. The hearings were widely advertised in newspapers across Ontario and were open to the public.

During the year, the Task Force received more than 500 written submissions from organizations and individuals. Approximately 180 organizations and individuals made oral presentations at the hearings. The names of all organizations and individuals who made written or oral presentations to the Task Force are listed in Appendix 2. We were greatly impressed by the sensitivity, knowledge and initiative of those who presented briefs.

The Task Force was extremely fortunate to visit midwifery care facilities and educational institutions and to meet with experts in the United States, United Kingdom, Denmark and Holland. We learned much about the provision of midwifery care in those countries within the context of their overall health care systems, and about the education and regulation of midwives. We saw places where midwives work, and talked to the midwives who work in them and the obstetricians who are their colleagues. At the World Health Organization in Copenhagen and at the London headquarters of the International Confederation of Midwives we learned about international trends in midwifery. We learned what seems to work well, what doesn't seem to work so well, and just as important, why. We returned to Ontario with a better grasp of the issues, a better appreciation of the range of possibilities, and a more accurate understanding of the current international status of midwifery. A detailed account of our travel appears in Chapter 2.

Within Ontario we were able to draw on the expertise of the Advisory Committee on Reproductive Care, which is composed of health care professionals and consumers from across Ontario and advises the Minister of Health on reproductive care issues. Task Force staff also met with officials of various branches of the Ministry of Health, and ongoing assistance was provided by members of a liaison committee appointed by the Ministry. Useful information and advice were also provided by officials of the Ministry of Colleges and Universities and the Ontario Women's Directorate.

The Task Force obtained information on midwives in the far North from officials in the Medical Services Branch of Health and Welfare Canada, and about midwives in the military from the Canadian Forces. Helpful advice and survey data on maternity practices in Ontario hospitals were obtained from the Canadian Institute of Child Health. The Institute also shared with us, with the permission of Health and Welfare Canada, a report on professional roles in reproductive care across Canada. Dr. Elizabeth Roberts of Kaministiquia, Ontario, Dr. Patricia A. Kaufert of the Department of Social and Preventative Medicine, Faculty of Medicine, University of Manitoba, and Norman Helfand of the staff of the Nishnawbe-Aski Nation discussed with us the needs of native women, particularly those in the North. C. Lesley Biggs shared with us her knowledge of the professional response to maternal mortality in Ontario in the 1920s and '30s. Dr. Stuart Lee of the Canadian Medical Protective Association and Karen Ehrnman of the American College of Nurse-Midwives discussed liability insurance issues with us. Jessie Chippet shared with us her experiences in 27 years of midwifery practice in rural Newfoundland.

We obtained information on the current status and future of midwifery in other provinces from representatives of the Canadian Association of Midwives; the Midwifery Task Force, Midwives' Association and Midwifery School of British Columbia; the Alberta Association of Midwives; and the Quebec Groupe de travail sur la profession de sage-femme. A member of the Task Force attended a conference on Midwifery in the Americas held by the Midwives' Alliance of North America in Vancouver.

The Task Force commissioned two surveys of existing midwifery resources in Ontario. One survey, co-sponsored by the College of Nurses of Ontario, was designed to investigate the midwifery education and experience of the 5400 registered nurses and registered nursing assistants who had reported in a previous College survey that they had midwifery preparation. The second survey, conducted by Norpark Computer Design Inc., was designed to investigate the education and experience of non-nurse midwives currently practising in Ontario, and non-practitioners with midwifery qualifications. Both the CNO and Norpark surveys also explored the nurses' and midwives' desire to practise as midwives, under specified conditions, and their willingness to upgrade or renew their qualifications. The Task Force was assisted by the Environics Research Group Limited in ensuring that the survey results would be objective and that the two surveys would produce comparable data.

Finally, the Task Force obtained the assistance of Jutta Mason, who shared with us many years of historical research into the evolution of midwifery care in Canada. Her historical account appears in this report as Appendix 1. To our knowledge this is the first comprehensive account of its kind to be published in Canada. Kate Hughes, then a student-at-law, assisted us in preparing for the public hearings, and prepared the report on submissions from the public that appears in Appendix 2.

The Task Force would be remiss if we did not express our gratitude to the many people who took the time to express their views and to inform us. We are grateful to the many midwives, physicians and nurses, educators, regulators and hospital and government officials in Canada and the U.S., U.K., Denmark and The Netherlands who shared their experience and knowledge with us. They were generous of their time and hospitality. The spirit of cooperation that animated our discussions with members of the health professions, and hospital and government representatives in Ontario, gives us confidence that the further steps necessary to accomplish the integration of midwifery into the health care system in this province will be taken in an atmosphere of goodwill and helpfulness. Our consultations have shown us that the interest in providing families with safe, high quality, and caring service is universally shared.

Notes to Chapter 1

[1] The vast majority of midwives everywhere are women. The pronouns "she" and "her" therefore will be used throughout this report to refer to midwives.

[2] The obstetrical forceps was invented in the 17th century by a family of English obstetricians, the Chamberlens. The family kept the forceps a secret for almost a century, until its design was revealed in 1773 by another obstetrician, Edward Chapman. From then on the forceps was available to all physicians (Rich, 1976).

[3] Other sects included the Thomasonians, the Grahamians, Eclectics and Homeopaths.

[4] In the late 1920s the results of a study of the outcome of all births taking place in Aberdeen County, Scotland between 1917 and 1929 became widely known in the medical world. The results indicated that the maternal mortality rate in cases handled by the physicians was much higher than the rate for midwives' cases, and that the rate for institutionalized cases was highest of all. U.S. studies published in the early 1930s also showed unfavourable maternal mortality rates among women delivered in hospital by physicians.

Chapter 2

OBSERVATIONS OF MIDWIFERY IN OTHER COUNTRIES

Introduction

The Task Force felt it was important to visit other jurisdictions to see midwifery practice and midwifery educational institutions first hand. We were interested in how other jurisdictions regulate midwives, and in how midwifery fits into their health care systems. We wanted to visit places where midwives have clearly defined roles and function autonomously within the health care system. We also wanted to visit places where midwives currently have difficulty functioning to the full extent of their potential roles, and find their place in the health care system threatened, or not yet fully realized. Obviously, no single model can be imported intact into Ontario and grafted onto our health care system. But the knowledge of what has and has not worked elsewhere has guided our thinking about what should be attempted here.

The Task Force obtained useful advice on where to travel and whom to see during the first set of consultations with medical, hospital, nursing and midwifery organizations. The limited amount of time at our disposal for travel, and the expense of international travel, forced us to restrict our itineraries to North America and Western Europe, and to be selective within these regions. In July and August, 1986, three members of the Task Force visited the United Kingdom (primarily England, with brief side trips to Scotland and Wales), Denmark and The Netherlands. Over the course of the year, individual members and the Task Force's Executive Director visited several places in the United States. In addition to our travel, which is described in detail in this chapter, our consultations provided useful information about midwifery practice in many other countries. While not detailed here, this information has also informed our thinking.

Within each country we visited, we tried to see a variety of practice settings and to meet with experts with differing points of view. Midwifery practice is heterogeneous and even in a country where midwifery has a long history and is respected as an autonomous profession, there are varieties of practice and differing opinions about what is "best". For example, in The Netherlands we were fortunate to meet with both Dr. G. J. Kloosterman, a leading proponent of home birth who is sometimes called the "godfather of modern midwifery", and Dr. J. De Haan, obstetrician-director of one of The Netherlands' midwifery schools and a well-known opponent of planned home birth. In England we met with both the United Kingdom Central Council for Nursing, Midwifery and Health Visiting, which is the regulatory body for midwives, and members of the Association of Radical Midwives, which is critical of the organization and nature of midwifery services in the U.K.

United States

Individual members of the Task Force and its Executive Director visited the Seattle Midwifery School in Seattle, Washington; the American College of Nurse-Midwives (ACNM), the midwifery program of the Georgetown University School of Nursing, and a private midwifery practice in Washington, D.C.; a private birthing centre operated by nurse-midwives in Bethesda, Maryland; the Frontier School of Midwifery and Family Nursing in Hyden, Kentucky; two nurse-midwifery practices in Cleveland, Ohio, one of them at a health maintenance organization (HMO) and the other in a private medical practice; the Maternity Center Association, a hospital based nurse-midwifery practice, and a private nurse-midwifery practice in New York City; the Yale University Maternal Newborn Nurse-Midwifery Program, and two nurse-midwifery practices in New Haven, Connecticut, one at an HMO and one at a community health clinic; and a midwife in Newton, Massachusetts. We also read the work of a number of historians and other scholars who have studied the history of American midwifery (Ehrenreich and English, 1979; Donegan, 1984; Kobrin, 1966; Scholten, 1984; Litoff, 1978; Wertz and Wertz, 1979 and 1983; Tom, 1982).

The most striking feature of the midwifery profession in the United States is that it consists of two entirely separate groups of midwives: those who first qualified as nurses, and then completed a recognized nurse-midwifery program leading to the designation certified nurse-midwife (CNM) and those who were prepared through a variety of other routes and are known variously as granny midwives, lay midwives, empirical midwives or direct entry midwives. (In this chapter we will call the second group "non-CNMs" to distinguish them from CNMs; in the rest of our report, the term "midwife" is used to identify someone whose profession is midwifery, regardless of whether she trained first as a nurse or entered the profession directly.) CNMs are quite homogeneous in educational background, philosophy, and standards of practice; non-CNMs are exceptionally diverse and include practitioners who have received formal education from direct entry schools of midwifery like that in Seattle, as well as apprentice-trained and self-taught practitioners. Non-CNMs espouse a variety of philosophies. While CNMs constitute a clearly identifiable profession, non-CNMs are in some respects more a movement than a profession, or a movement as well as a profession. They are the American counterparts to the midwives currently practising in Ontario outside the official health care system.

History of U.S. Midwifery

The Decline of the Granny Midwife

Midwifery declined during the first half of the 20th century, a casualty of efforts by public health workers, reformers, and the medical profession to improve the maternity care available to the poor. By the 1900s, obstetricians and general practitioners were providing maternity care to those women who could afford them. Empirically trained and self-taught midwives, often referred to as granny midwives or grannies, served the rest. These midwives were usually of the same race and national origin as their clients, and the largest numbers were practising in the American South. The majority practised midwifery part-time, attending fewer than five births a year (Anisef and Basson, 1979). Many U.S. physicians believed that there was a "midwife problem" and their belief led to several official investigations and reports on midwifery practice. One of the most influential was an investigation in 1906 of midwifery practice in New York City by the Public Health Committee of the Association of Neighborhood Workers. The report—often quoted in subsequent years—was an indictment of the granny midwife:

> The majority of these so called midwives are foreigners of a low grade—ignorant, untrained women who find in the natural needs and life long prejudices of the parturient woman a lucrative means of livelihood .As for [their] bags and equipment, from a professional standpoint by far the greater number make fit decorations for a chamber of horrors. Rusty scissors, dirty string, a bit of cotton, a few corrosive sublimate tablets, old rags and papers, some ergot, vaseline, a gum catheter, and wire were the usual contents. (quoted in Harris, 1969)

Nearly half the midwives studied were said to hold "utterly worthless" diplomas from so called schools of midwifery or certificates of competence from greedy, colluding physicians (Harris, 1969).

The first investigations conducted by the United States Children's Bureau, which had been founded in 1912, revealed alarmingly high infant and maternal mortality rates; most of the infant and maternal deaths were classified as preventable. The Bureau's surveys disclosed that there were about 45,000 granny midwives without formal training practising in the United States, and that no one was prepared to train or supervise them.

The belief that the poor infant and maternal mortality statistics resulted from inadequate maternity care service may or may not have been well-founded, and it led to several different responses. One opinion was that the midwives should be ignored, partly because legal recognition of them would give them status and "create a new order of medical practitioners who, with little skill and less learning, will not hesitate to assume the greatest responsibility of life and death in connection with treatment of many ills" (Harris, 1969, p.6) and partly because the problem would disappear on its own as recent immigrants assimilated into American society and immigration from southern Europe was restricted. Many physicians held this view (Harris, 1969; Anisef and Basson, 1979). Another view was that midwives should be given proper training and regulated by the state. In general, the southern states gave legal recognition to midwifery and sought to regulate it, while the northern states advocated abolition (Burst, 1983). An exception was New York City, where in 1911, the first American school for midwives was opened at Bellevue Hospital. This school, which offered a six-month course of instruction for its students, who were not nurses, operated until the mid-1930s.

Various states imposed regulations and training requirements on lay midwives, 29 eventually requiring licences. Sometimes these requirements could not possibly be met; for example, six states required that the licensed midwife be a graduate of an approved midwifery school but there were only three approved schools in the entire United States, located in just two cities, Philadelphia and New York. Scholars have concluded that "the net effect of Medical Practice Acts, inadequate budgets, poor educational facilities, and the perpetuation of an 'incompetent midwife' ideology by medical professionals was a drastic reduction in the numbers of births attended by midwives" (Anisef and Basson, 1979). In New York City alone, the 3,000 practising midwives in 1905 were reduced to 863 licensed midwives by 1932 (Harris, 1969). The trend away from the granny midwife was reinforced by the shift from home to hospital birthing during the 1920s, '30s and '40s, (Devitt, 1977; Wertz, 1983) and by such social factors as the low status of women and competition in the practice of medicine. It was also reinforced by the idea that the appropriate role for women was to be passive recipients of obstetrical care provided by men (Burst, 1983). Popular women's magazines such as *Good Housekeeping* and *Ladies Home Journal* advanced the idea that the modern American woman was delivered in hospital by an obstetrician (Radosh, 1986).

The Rise of Certified Nurse-Midwifery

While the number of granny midwives was waning, the idea of "nurse-midwife" was emerging. Public health advocates familiar with the role in other countries of midwives who were also nurses advocated the nurse-midwife for the United States as early as 1911 (Harris, 1969). In 1917 the Children's Bureau drew up plans for "the public protection of maternity and infancy" that included provision of prenatal instruction and care by public health nurses (Hogan, 1975).

The effectiveness of nurse-midwives was soon proved. In 1925, Mary Breckenridge, a well-connected woman who had worked as a nurse with the Children's Bureau and trained as a midwife in Britain, established the Frontier Nursing Service in Leslie County, Kentucky. The service was intended to bring health care to an impoverished mountainous region of the state to which there was access only by foot or horseback. There was no doctor to serve the population of 10,000. Granny midwives provided the only available maternity care. The record of the Frontier Nursing Service has become legendary in the annals of nurse-midwifery: throughout its history its maternal death rates have been lower than those of the United States as a whole, despite the poverty and resulting health problems of the inhabitants of the region. For its staff, the Frontier Nursing Service recruited British midwives and sent American nurses to Britain for midwifery training. This pattern continued until the outbreak of World War II when the British went home and the American nurses could no longer be sent to Britain to study. The Service was forced to open its own school of midwifery in 1939. Both the Frontier Nursing Service and its school exist today, but there have been many changes in the way care is provided.

In New York City, a group of obstetricians, mothers and nurses founded the Maternity Center Association in 1918. Their objective was to provide better maternity care through family education and prenatal care provided by nurses with specialized education. However, they immediately encountered a shortage of public health nurses with adequate maternity care training. In 1931 the Maternity Center Association opened the first American school of nurse-midwifery at the Lobenstine Midwifery Clinic, which cared for immigrant women in upper Manhattan. Between 1931 and 1951, 5,765 mothers were registered with the clinic, of whom 87 per cent gave birth at home attended by nurse-midwives.

The clinic achieved a maternal mortality rate of less than one-third the national rate. Its average neonatal mortality rate was 15 per 1,000 live births while those for New York City as a whole ranged from 28.0 in 1931 to 18.4 in 1951 (Faison, 1961). The Maternity Center Association no longer operates a school, and its home birth service was closed in the late 1950s. In 1975 it opened a birthing centre located in its Manhattan headquarters (Lubic, 1981).

During the 1940s nurse-midwifery schools and services were established in Alabama and New Mexico. These programs, too, demonstrated the improvements in maternal and perinatal mortality that nurse-midwives could achieve working with mothers in socially and economically deprived conditions. The United States government came to rely on nurse-midwives to deliver care to low-income women and the wives of armed forces personnel. During the next three decades nurse-midwifery programs were opened at a number of universities and nursing schools throughout the United States. Nurse-midwives held important positions within the Children's Bureau and were active within nursing professional organizations. In 1955 the American College of Nurse-Midwives was incorporated. It is the professional organization and certifying body for CNMs.

As its history demonstrates, nurse-midwifery began by bringing care to the poor, to ethnic minority populations in inner city ghettos and to isolated rural areas. Nurse-midwifery was closely associated with the public health movement and public health nursing, and the majority of nurse-midwives were employed by government departments and agencies and charitable organizations.

The pattern in the United States began to change in the 1970s as a new market for nurse-midwifery care developed. A growing number of assertive, well-educated, affluent women wanted childbirth to be an emotionally rich experience and believed that the medical model of childbirth was unnecessary and harmful. They sought female, non-authoritarian caregivers. These women created a demand for CNMs in the private sector, and at the same time influenced the re-emergence of midwives who are not nurses. In response to this demand, CNMs began to establish private practices (Beach, 1984). Some delivered babies at their clients' homes, others developed or were employed by free-standing birth centres. They began to seek hospital privileges. Partly to provide a desired service to their clients and partly to reduce costs, health maintenance organizations (HMOs), which provide comprehensive primary health care services and hospitalization for a fixed annual charge, also hired CNMs.

According to a 1984 survey by the ACNM there are approximately 1,653 nurse-midwives currently working in clinical practice in the United States and about 242 nurse-midwives working in non-clinical maternal and child health positions (Rooks and Haas, 1986). By comparison, the U.S. has approximately 26,000 specialists in obstetrics and gynaecology and about 42 per cent of its 67,000 general practitioners and family physicians have hospital obstetrical privileges (Harsharm, 1983; American Medical Association, 1987). Almost all CNMs are women, and about half are married and in their thirties. About 90 per cent are white. An earlier survey conducted by the American College of Nurse-Midwives in 1982 revealed that more than three-quarters of CNMs who responded to the survey completed their basic nurse-midwifery education after 1970, and almost two-thirds hold degrees at a Master's level or higher (American College of Nurse-Midwives, 1984).

CNMs practise in almost every state. Most deliveries by CNMs take place in hospitals, with only 14 per cent of CNMs surveyed in 1982 reporting that they conducted deliveries in private homes and 12 per cent in free-standing birth centres. Between 1976-77 (when a previous survey was conducted by the ACNM) and 1982 there was a trend toward more CNMs working in private practices. The average number of deliveries per year per CNM conducting deliveries appears to be increasing, as does the proportion of U.S. births managed by CNMs. The 1984 survey showed that CNMs conducting deliveries did an average of 159 each per year, accounting for nearly 4 per cent of babies born in the U.S. in 1983. This was a significant increase from the 1982 survey, which showed an average of 73 births per CNM per year, accounting for 1.8 per cent of U.S. births. The largest numbers of CNM practices, CNMs and CNM deliveries in 1982 were in California, Florida and Pennsylvania. Although CNM practice is oriented toward normal pregnancies and deliveries, a majority of CNMs reported that they also cared for women with the potential to develop selected high risk characteristics.

The mean annual income for CNMs engaged in direct patient care in 1982 was $22,382 U.S. Only 9.1 per cent of nurse-midwives engaged in direct patient care reported incomes of over $30,000. By comparison, the average net income of obstetrician-gynaecologists in 1982 was $115,800 U.S. (Lubic, 1985).

Education

The American College of Nurse-Midwives accredits educational programs for CNMs. All CNM students are, of course, graduates of recognized nursing schools. The great majority of CNM programs are located at university schools of nursing. There are currently nine certificate programs, 16 Master's level programs and one doctoral program. It is important to note that all these programs are "basic" programs, teaching the "core midwifery competencies" standardized by the ACNM. That is, while the certificate or degree awarded reflects the level of the student's academic attainment, everyone graduates with the same level of midwifery skill. Nurses with either diploma or degree level nursing education may be admitted to certificate level CNM programs, which are generally about 12 months in duration. Master's level programs are 18 to 24 months long. There is one program in the United States, at Yale University, which combines both nursing and midwifery. It is open to students who already possess a university degree in any field. The students study nursing for the first year. During the second and third years they study with students who previously trained as nurses and are enrolled in the regular Master's program in midwifery.

We visited the Georgetown University nurse-midwifery program, which is administered by the School of Nursing. The current program is at the Master's level, having replaced a certificate program that was offered from 1973 to 1980. There are approximately 12 students per class. Admission requirements include at least one year of obstetrical nursing, and every applicant is interviewed to ensure she has the requisite personal qualities, one of which is assertiveness. There are many more applicants than places, although the number of applicants for fall 1986 dropped substantially; the drop was attributed by the school to concerns over the impact of the liability insurance crisis on midwifery practice. The program, like more than half of U.S. nurse-midwifery programs, uses a "mastery learning curriculum" in which students must master one section or module of the curriculum before moving on to the next. The student-faculty ratio is two to one, which is believed to be necessary to ensure students receive proper supervision. Clinical experience is obtained at several hospitals and at a birthing centre. A faculty midwifery service was established so that the teaching faculty can maintain their skills and serve as role models for students.

CNM Practice

CNMs are regulated both by their professional organization, the ACNM, and by state licensing boards. The ACNM certifies midwives who are graduates of the educational programs it accredits and who pass the national certification examination it administers. There are ACNM standards of practice; an important one is that certified CNMs are required to have "collaboration agreements" with physicians, for back-up and consultation. The ACNM is developing continuing education requirements and has published guidelines for quality assurance and peer review.

However, legal authority to practise is granted (or withheld) by each state. By January 1986, only North Dakota lacked clear statutory provisions regarding nurse-midwifery. Every other state had some form of statutory regulation of nurse-midwifery. The instruments of regulation are extremely varied. In 35 states nurse-midwives are regulated by boards of nursing; in five states they are jointly regulated by boards of nursing and medicine; in four states they are regulated by boards of medicine alone; in six states they are regulated by departments of public health; in one state, Utah, they are regulated by a committee of certified CNMs within the department of business regulation. Forty-three states recognize either ACNM certification or graduation from an ACNM accredited education program as the basic requirement for practice. Four states require baccalaureate or Master's degrees for nurse-midwifery practice.

Nurse-midwives' scope of practice also varies from state to state. In 18 states certified CNMs have authority to write prescriptions and in most states they can sign birth certificates. Many states require a CNM to provide written evidence of a collaboration agreement with an obstetrician- gynaecologist. There appears to be variation in the degree of autonomy permitted by the states. For example, in Ohio, the *Medical Practice Act* states that midwives "at all times shall practice midwifery under the direction and supervision of a doctor of medicine or doctor of osteopathic medicine and surgery holding a license to practice medicine or surgery".

Nurse-midwifery services are being increasingly recognized by insurers. More than 42 states have authorized Medicaid reimbursement for nurse-midwifery services to low-income women. More than 16 states require private insurance companies to provide reimbursement for nurse-midwifery services, and voluntary reimbursement is made in most states (Radosh, 1986).

However, while CNMs themselves appear to have a clear sense of their professional role and identity, and of the contribution they can make to the health care system, they have not yet entirely succeeded in communicating this to other health care providers and to the general public. In a 1985 ACNM survey of

CNMs, the two problems most often cited as obstacles to the success of nurse-midwifery were lack of understanding among the general public and misunderstanding or negative attitudes toward nurse-midwifery among other health professionals.

The lack of understanding and appreciation for nurse-midwifery services expresses itself in various ways. One obvious way is the number of clients CNMs attract. We interviewed a CNM who had opened a private practice in Washington, D.C. in March, 1985; one year later she was working a full shift as a labour and delivery room nurse to supplement her practice income. We visited a CNM service operated in a birth centre adjacent to Booth Hospital in Cleveland, Ohio. At the time of our visit in June, 1986, it was under-utilized, enrolling 15 to 20 patients a month, below the capacity of 30. (However, the under-utilization cannot be attributed solely to the fact that the caregivers are CNMs since the hospital itself is under-utilized.) The CNMs were hoping to launch an advertising campaign for the birth centre.

For much of its history, nurse-midwifery's goal was to achieve recognition by differentiating nurse-midwives from so-called granny midwives. In the 1970s and '80s CNMs were criticized for reaching their goal too well: the literature of the alternative birthplace and home birth movements faulted them for having been co-opted by doctors and for offering no real alternative to the medical model of childbirth. This may help to explain why CNMs have found it difficult to carve out a niche in the market, between obstetricians on the one hand and non-CNMs on the other.

The lack of understanding and appreciation for CNMs among doctors has sometimes made practice, especially private practice, difficult. During the 1930s, 1940s and 1950s, when nurse-midwifery was emerging in the United States, residency programs in medical specialties were growing, and the specialist was starting to eclipse the general practitioner. It was difficult for nurse-midwifery to flourish in an atmosphere in which the goal apparently was to have every baby delivered by an obstetrician (Harris). Although the American College of Nurse-Midwives and the American College of Obstetricians and Gynaecologists have issued official joint statements approving "interdependent practice" and cooperation, opposition from physicians was renewed when CNMs began to enter private practice. The American Academy of Family Physicians continues to state that "obstetrics should be practised only by fully licensed qualified physicians" and that "a nurse practitioner should not function as an independent health practitioner". Physician opposition can make it very difficult to obtain a collaboration agreement with a physician, without which a CNM cannot practise privately in many states and cannot adhere to ACNM standards. Hospital committees and insurance companies dominated by physicians have thrown obstacles in the way of CNMs obtaining hospital privileges and liability insurance, forcing some CNMs into the courts and legislatures. While the Federal Trade Commission is committed to removing barriers to professional CNM practice, the campaign is not yet fully won (Bailey, 1984).

A 1984 American Hospital Association survey of nonfederal, short-term general acute care hospitals found that less than seven per cent of responding hospitals had nurse-midwives on staff; only 10.3 per cent had by-laws which permit them to be on staff. The by-laws of only 0.9 per cent of the hospitals permitted nurse-midwives to admit patients under their own authority. However, revised standards of the Joint Commission on the Accreditation of Hospitals, the accrediting body for U.S. hospitals, which permit hospitals to appoint non-physician practitioners to the medical staff, took effect in 1985; the revised standards may help to make it easier for CNMs to obtain hospital privileges (Morrisey and Brooks, 1985).

CNMs were badly affected by the crisis in professional liability insurance. From 1974 to 1983 the ACNM sponsored professional liability insurance for its members through the Chicago Insurance Company. In 1983, the policy was moved to the Home Insurance Company because of increasing premiums. In 1984 Home did not renew the policy because it was no longer writing medical malpractice insurance. The program was shifted to the Mutual Fire, Marine, and Inland Insurance Company, which, only one year later, cancelled the policy because the company lost its reinsurance. The ACNM then contacted 17 insurance companies known to write medical malpractice insurance. Although only six per cent of CNMs have ever been sued, these companies were unwilling to issue a policy because of lack of reinsurance and the general deterioration in the liability insurance industry due to increasing litigation and high malpractice settlements. Between July and December 1985, CNMs were able to find temporary policies on a state-by-state basis; in a few states, the Joint Underwriting Authority (a state-sponsored insurance program providing liability insurance to health care providers where no other source of insurance is available) was extended to CNMs. Some CNMs obtained coverage for insurance available to nurses in their states, a hazardous measure because many aspects of midwifery are outside the scope of nursing practice.

In late 1985, the ACNM decided to try to establish a "captive" insurance company (a company organized for the primary purpose of insuring the members of the founding organization) for its members and during the first half of 1986, it engaged in lobbying efforts at Congress to enable such a company to be established. Despite vigorous opposition from the insurance industry, the necessary legislative amendments were passed. As a result of improvement in the U.S. insurance climate, political pressure, and reform in the tort laws of a large number of states, the ACNM was able to obtain an insurance policy in mid-1986, underwritten by a consortium of 10 companies. The policy, which is underwritten separately for each CNM who applies, provides $1 million coverage at a premium cost of $3,500.

As was mentioned earlier, CNMs have been criticized for providing care that is no different from care given by doctors. In many practice settings CNMs do not control how their services are provided; this is the prerogative of their employers. The Kaiser Permanente Clinic we visited in Cleveland, one of several such clinics in the area, employs one CNM and several obstetricians. The CNMs are part of the obstetrics and gynaecology service and report to its chief. They may attend department meetings but cannot set policy themselves. Each CNM works four days a week in the clinic providing pregnancy, post-partum, well-woman and family planning care, and one day a week in the labour and delivery suite of the hospital utilized by the clinic. Some continuity of care can be provided in the clinic, but not at the hospital. Moreover, at the hospital the CNMs must adapt their style of care to the requirements of the back-up obstetricians who rotate through the suite. At the clinic, prenatal appointments are scheduled every 15 minutes (30 minutes for first appointments), and the CNM we interviewed acknowledged that she has little time to spend in discussion with her patients.

On the other hand, at other nurse-midwifery services we visited — both hospital and community based — CNMs appeared to have been more successful in influencing, if not controlling, the organization and quality of care. One such service was that at Metropolitan Hospital in New York City, where a group of CNMs run prenatal and postnatal clinics and conduct deliveries for an inner city population. The CNMs are considered part of the medical staff, and the head of the service and the chief of the department of obstetrics and gynaecology work closely together. The CNMs teach midwifery students, medical students and residents. The CNMs and nurses in the labour and delivery suite are supportive of each other and there appear to be no problems or strains in defining their respective roles.

We were particularly impressed by the birthing environments CNMs had created at free-standing birthing centres. At the birthing centre we visited in Bethesda, Maryland, for example, which is owned and operated by a group of CNMs, pregnancy, labour, birth, and postpartum care is provided in a comfortable, brightly decorated house. Children and partners of labouring women may be present at all times. There are no institutional rules or protocols to interfere with the plan of care decided upon by the CNM and her client.

Midwives Other Than CNMs

As was stated earlier, midwifery in the U.S. is very different from nurse-midwifery. Because the profession is so diverse, it is more difficult to make general statements about it than about nurse-midwifery.

The term "non-CNM" refers to several different kinds of midwives. Some have trained by apprenticing to other midwives, others have attended private midwifery schools or have studied by correspondence, still others are primarily self-taught through a combination of reading and experience. Many non-CNMs began as childbirth educators, then became labour coaches and then midwives. Some are registered nurses with additional midwifery skills, who choose to work outside the hospital system and are not certified by the ACNM. A few religious sects, such as Hutterites and The Farm in Summerton, Tennessee, train midwives primarily to serve their own communities. What the majority of non-CNMs appear to have in common is that they have rejected the physician-oriented medical model of childbirth.

Non-CNM Practice

The number of non-CNMs practising in the U.S. is uncertain. The Midwives Alliance of North America (MANA), which was founded in 1982 to promote midwifery and function as a professional organization for midwives, estimates that there are 6,000 to 10,000 non-CNMs currently practising in the U.S. and Canada. It believes its membership of 500 practising midwives is less than five per cent of the total number. By contrast, a 1984 report of the U.S. National Center for Health Statistics states that in 1976 there were approximately 1,800 "lay or 'granny'" midwives practising in the U.S. Other estimates range from 2,000 to 3,000 (Sallomi, 1982).

Non-CNMs are closely associated with the home birth movement. Together with consumer supporters, they have formed such organizations as the National Association of Parents and Professionals for Safe Alternatives in Childbirth (NAPSAC), Informed Homebirth, and the Association for Childbirth at Home, Inc.

However, non-CNMs have been less successful than nurse-midwives in achieving legal recognition. According to a survey conducted in 1982 they have clear legal recognition in fewer than 10 states, and they are clearly prohibited from practising in nine. In about a dozen states the climate is generally tolerant of non-CNMs and there are no laws recognizing or prohibiting them. In other states, the climate is not as tolerant and there sometimes are hostile state legal opinions or case law. In states where non-CNMs are legally recognized and regulated by statute, they are subject to different, more restrictive regulations than certified nurse-midwives. Nowhere in the U.S. do non-CNMs have hospital privileges or coverage by Medicaid or private health insurance. Non-CNMs are not employed by hospitals, but some work in free-standing birthing centres (Sallomi, 1982).

Non-CNMs' lack of official recognition has not prevented them from attracting a clientele of well-educated, middle-class women, women sometimes described as "Yuppies", as well as women living what are often called "alternative lifestyles". In contrast to CNMs' clients, many of whom are unable to choose other caregivers because they are dependent for care on public agencies, the clients of non-CNMs are usually clients by choice. However, some women likely do choose non-CNMs and home birth by default, because they cannot afford doctors and hospitals.

It is difficult to say how many births non-CNMs attend. According to the National Center for Health Statistics, the 33,914 babies delivered outside hospital in 1979 were attended in about equal numbers by physicians, midwives and other unspecified attendants. This number includes women "for whom hospital delivery is not feasible for geographic or economic reasons, and unplanned out of hospital births, as well as women choosing to deliver at home because of the desire for a more natural, family-centered birth experience and the opportunity for immediate bonding between baby and mother" (Taffel, 1984).

For a description of how non-CNMs practice, we have no better source than *Having a Baby in Europe*, a report of the World Health Organization. Between 1979 and 1985 WHO conducted a detailed study of pregnancy and childbirth services in its European Region. The study included what it termed "alternative services" in Canada and the United States, services outside the publicly financed and private medical care sectors — services provided almost wholly by midwives, and in the U.S., especially non-CNMs. The study identified a number of characteristics as common to lay midwifery in all countries where lay midwifery has emerged as an important form of alternative perinatal services. It said that pregnancy care provided by lay midwives is based on a broad approach to preparation for childbirth, including such things as counselling, dietary advice, massage and yoga. Lay midwives emphasize the importance of a good personal relationship between mother and midwife; if the "vibrations" are bad, the midwife may refuse to take the woman as a client. Lay midwives are skeptical toward routine obstetrical interventions, but are rarely as cautious about the safety and effectiveness of alternative methods such as herbal remedies. Lay midwives are flexible about alternative birthing positions; for example, if birth occurs with the mother in an upright position, it is more likely because the mother has been moving around freely in labour and has given birth in the most comfortable position for her, rather than because the midwife has insisted on an upright delivery.

Such books as *Spiritual Midwifery* by the U.S. midwife Ina May Gaskin, and accounts of midwifery in popular and scholarly literature, indicate that these features are characteristic of U.S. midwives.

The U.S. non-CNM profession has demonstrated a somewhat ambivalent attitude toward obtaining legal recognition and becoming integrated into the official health care system. Some non-CNMs appear to feel that this inevitably leads to co-option and the loss of the distinctive alternative they offer. One exponent of this view is Raymond DeVries (1985), a sociologist who has written widely about midwifery and has compared CNMs and non-CNMs. DeVries argues that in contrast to the certified CNM, who has been the subject of medical socialization during her lengthy formal education, the non-CNM is able to maintain a skeptical attitude toward organized medicine. According to DeVries, almost all non-CNMs have had babies themselves, often both in hospital and at home, whereas CNMs are more likely to be childless and to have acquired all their knowledge about birthing in a medical setting and under the direction of doctors. He points out that CNMs working in institutional settings must adhere to policies and protocols and are not free to choose their clients. Non-CNMs who work on their own or in groups can control every aspect of their practice (Devries, 1985).

Non-CNM Education

There are far fewer formal educational opportunities for non-CNMs in the U.S. than there are for nurse-midwives. Organizations such as Informed Homebirth/Informed Birth and Parenting offer workshops for midwifery apprentices and labour coaches. Northland Pioneer College, a state-supported community college located in a rural area of Arizona (a state which will license non-CNMs) offers a two-year, two days a week program in "midwifery knowledge base training". The program is intended to provide students with the necessary knowledge base to write the state licensing examination, but it does not include clinical experience, which students must arrange independently with preceptors. The College informed us that "our ... program was developed as a 'model' for other schools in the state of Arizona to follow, but no other schools will 'touch it' due to insurance/liability and other concerns. We have only agreed to offer it again on condition we have no part of clinical training and its accompanying liability." At our public hearings, we were told about a midwifery program in El Paso, Texas, which offers intensive clinical experience in delivering high risk women. The Task Force wrote to all midwifery education programs and organizations listed in a catalogue published in *Mothering* magazine. Many of our letters were returned by the post office, and overall we received few replies.

A member of the Task Force visited the Seattle Midwifery School, which offers the only comprehensive direct entry program of non-CNM education in the U.S. The 2 1/2 year program includes approximately 12 months of classroom learning and 12 to 15 months of clinical experience; as at the Northland Pioneer College program, preceptorships must be arranged by the students themselves. Entering students are required to have two years of university education. The school is accredited by the State of Washington; its graduates are eligible to write a state licensure examination and, if successful, use the designation L.M. (licensed midwife). The school operates with a part-time faculty of CNMs, licensed midwives, physicians and childbirth educators. At the time of our visit in May, 1986, the class size was eight to nine students, which was somewhat smaller than in previous years. The faculty do not directly supervise the students' clinical experience, but students must submit regular reports and prescribed assignments. The clinical preceptors include licensed midwives, CNMs and physicians. In order to observe and manage the numbers of births required for graduation, most students need a hospital placement. About half the students are placed in a hospital in St. Lucia in the West Indies. The Seattle Midwifery School has a good relationship with the state licensing authority, and its faculty and students seem to be highly committed. However, graduates of the school obtain no official academic recognition for their studies; indeed, graduates who are registered nurses cannot write the ACNM certification examination to qualify as CNMs.

Current Trends in Midwifery

Non-CNMs, whether licensed or not, continue to attract the opposition of physicians. Some of the opposition originates in physician opposition to home birth. Physicians are also concerned about their legal liability if they provide medical backup in cases managed by non-CNMs and they sometimes fear they will lose their own insurance coverage if they support uninsured midwives.

In several states, organizations of non-CNMs are currently pressing for legal recognition or better treatment under the law. MANA is slowly developing a national certification program for midwives, which would standardize their education and clinical experience. However, those who are working to "professionalize" are balanced by others who fear the implications of professionalization. They argue that formal educational requirements will exclude experienced older women and that superficially supportive state laws may impose requirements that are in fact unattainable.

Conclusions

Foreign observers regard midwifery in the U.S. as anomalous in its creation of the practitioner called "nurse-midwife". The sharp division between her profession and that of the non-nurse midwife is viewed as unfortunate. It was our impression that both nurse-midwifery and non-nurse midwifery have suffered from this bifurcation and that it is a fundamental obstacle to full public acceptance and appreciation of midwifery care. On the level of the individual practitioner, the lack of communication between CNMs and non-CNMs is striking. In our view, the U.S. situation exemplifies the problems that may result from recognizing CNMs but not non-CNMs or, if both are recognized, from regulating the two groups under separate statutory regimes.

The future success of U.S. midwifery seems to depend, to a great extent, on such matters beyond midwives' complete control as the availability of liability insurance, support from physicians, and acceptance by hospitals. While the crisis in liability insurance appears to have passed for CNMs at least temporarily, little can be done to prevent its return.

Whether physicians and hospitals become readier to accept and support CNMs may depend more on economic forces in the health care sector and less on demonstrations of CNMs' competence. We have been greatly impressed by the vitality of individual CNMs and non-CNMs, and we admire their hard work on behalf of midwifery. At the same time, we feel that the structure of midwifery in the U.S. is an undesirable model, and that Ontario must develop its own way of integrating midwifery into the health care system.

The Netherlands

Everyone we consulted recommended that we include The Netherlands in our itinerary. It is usually pointed out that The Netherlands is the last remaining industrialized nation with a high proportion of planned home births — and that this coincides with low rates of perinatal mortality. Dutch midwives are described as independent practitioners who have succeeded in resisting the "medicalization" to which midwives elsewhere in the industrialized world have, to a greater or lesser degree, succumbed.

Our expectations of what we would see in The Netherlands were not disappointed: it is indeed a country where pregnancy and childbirth are regarded as normal, physiological processes, rarely requiring medical interventions. However, we also learned that there are unresolved controversies among caregivers in The Netherlands and that the quality of care varies from the ideal to something less than that. Dutch midwives are ever vigilant to protect their profession from medical incursions, and indeed, the entire system purposefully protects midwifery.

Social Context

Dutch midwifery must be understood within its social and geographic context. The Netherlands is one of the most densely populated countries in the world, with approximately 14,394,400 people inhabiting just 41,160 square kilometres (15,892 square miles, about the size of Nova Scotia). The country was urbanized during the 20th century, and over 88 per cent of the population now lives in cities and towns. There is a sizeable immigrant population in The Netherlands, with immigrants during this century coming mainly from the East

Indies and Surinam; there are also several hundred thousand foreign workers. This population has posed new challenges to the Dutch health care system; as in Denmark, providers of obstetrical care in facilities serving the immigrant community are developing an awareness of cultural differences in birthing customs, and learning to accommodate to them.

The government provides extensive social insurance programs. The Health Insurance Act, administered by employer-employee boards, covers approximately 71 per cent of the population and is compulsory for everyone earning below a specified income level. Twenty-seven per cent of the population have private health insurance, and two per cent are uninsured. Physicians (both obstetricians and general practitioners) and midwives, other than those who are directly employed by hospitals, are self-employed and paid on a fee-for-client basis by their clients or the health insurer. The Netherlands has fewer hospital beds than many other West European countries: one per 206 persons.

The birth rate has declined during this century and in 1983 (the last year for which we have statistics) was 11.8 per 1,000 population. Because of the decline in the birth rate, aging of the population and limited immigration, the average annual growth rate of the population was only 0.4 per cent between 1971 and 1981 and since 1981 the population has actually decreased. In 1984 the perinatal mortality rate was 10.03 deaths per 1,000 live births. This rate is somewhat higher than the perinatal mortality rates of the Scandinavian countries.

Midwives have played an important role in providing maternity care in The Netherlands for many years. Since 1865, midwives have been licensed by the state to act as obstetrical practitioners. Midwifery in The Netherlands is not allied to nursing, but is regarded as a "medical profession". One consequence of this is that midwives, together with physicians, dentists and pharmacists are regulated in matters of discipline by a single college. It is interesting that midwives, like physicians, swear the Hippocratic oath.

At the beginning of the 20th century, efforts were made in The Netherlands, as elsewhere, to improve infant and maternal care. However, unlike North America, where the efforts of the public health movement were focussed largely on improving access to medical care, moving women into hospital and improving the quality of hospital care, in The Netherlands efforts were also directed toward improving the home as a suitable place for giving birth (Kloosterman, 1982 and 1984). It was recognized that mothers giving birth at home need housekeeping help as well as midwifery care, and in 1904 a number of organizations were established to train young women to work as maternity aides. During the course of this century the maternity aide system was expanded and improved so that now maternity aides are skilled auxiliaries to midwives. However, recent proposals to establish a single longer education program for maternity aides and other home workers have raised concerns in some quarters that young women ideally suited to working as maternity aides will no longer be attracted to the occupation.

Midwifery Practice

There are approximately 1,000 licensed midwives in The Netherlands. Seventy per cent work in private practices, 30 per cent as salaried employees in hospitals and clinics. Midwives currently handle about 42 per cent of deliveries in The Netherlands, obstetricians handle about 43 per cent and general practitioners less than 15 per cent. Since 1970 the proportion of deliveries conducted by general practitioners has decreased, while the proportion handled by midwives has stayed constant. Obstetricians, whose numbers have increased much more than midwives and general practitioners over the past 15 years, have gained the share lost by the general practitioners.

The diagnosis of pregnancy is usually made by the woman's general practitioner, although midwives sometimes make the diagnosis and would like to be able to do so more often. The general practitioner usually refers the woman to a midwife or obstetrician. The decision to refer to a midwife or obstetrician (or in the case of women who have self-referred directly to a midwife, whether they should remain with the midwife or be referred to an obstetrician) is based on whether the pregnancy is classified "physiological" and therefore appropriate for a midwife, or "pathological" and therefore appropriate for an obstetrician (Keirse, 1982). The division between physiological and pathological pregnancies is very definite, and follows a list of indications drawn up some years ago by Dr. G. J. Kloosterman. At the time of our visit, the list was being revised by a committee of midwives and obstetricians. The new list will have three classifications: physiological, pathological, and a third group of patients who must deliver in hospital, but who, unless problems actually develop, may be cared for during pregnancy and attended at birth by midwives or general practitioners.

For normal pregnancies and deliveries, both the state and the private health insurance plans pay only for midwifery care, unless no midwife is available in the area. In areas without midwives, normal deliveries are conducted by general practitioners. If a woman wishes her general practitioner or an obstetrician to conduct her delivery when there is no specific indication of medical need and a midwife is available, she must pay the fees herself. Similarly, the costs of hospital delivery are insured only if hospitalization is indicated by medical or social criteria. While some of the people we interviewed in The Netherlands acknowledged that these restrictions limit the woman's right to choose her caregiver and place of delivery, some also felt they are necessary to protect the interests of midwifery. The restrictions have also served to ration hospital services and to reduce costs (Butler and Lapre, 1986).

Midwives are legally permitted to undertake the care of a woman during normal pregnancy, labour and birth, and the postpartum period. This mandate includes such acts as attempting to turn a breech baby (one who is presenting bottom first) and administering anti-haemorrhagic medication after delivery. They may not administer drugs to stimulate labour. Although they are permitted to perform and repair episiotomies (incisions to enlarge the vaginal opening), they do not do many. They may administer local anaesthetics for suturing tears and episiotomies.

Throughout the pregnancy the midwife monitors whether the woman requires referral to an obstetrician. The indications for referral are set out in the standard Dutch textbook for midwifery and medical students, and are also published by the advisory council to the state health insurance system. We have included them in our Report as Appendix 6. Until recently, midwives could lose their fees if they transferred women to an obstetrician. It was recognized that this might discourage or delay necessary referrals, and changes were made so that the midwife is remunerated in full for the pregnancy care she has given up to the referral, provided she has cared for the woman for at least 28 weeks of pregnancy. However, it is estimated that in 30 per cent of cases, the insurance system pays both a midwife and an obstetrician, a duplication which obviously adds considerably to the total cost of maternity care.

The proportion of home to hospital births has declined markedly since mid-century. In 1952, 72 per cent of all births occurred at home; this declined to just over 30 per cent in the early 1980s and has now levelled off at 34 to 36 per cent. There are large regional differences in the proportion of home births, with the proportion generally lower in the large municipalities than in the smaller towns. There are also variations among the larger towns and cities. For example, between 1979 and 1982, 80.5 per cent of deliveries in Amsterdam were in hospital, while only 50.5 per cent of deliveries in Apeldoorn were in hospital (Treffers and Laan, 1986). Approximately half of hospital births are "policlinical births", in which the mother and baby are discharged within 36 hours of delivery (Butler and Lapre, 1986).

Two midwives at a leading private clinic have written that they attribute the decline in the proportion of home births partly to an increase in the "so called voluntary preference to deliver in hospital" but mainly to an increase in medical indications "dictated by obstetricians". In their view, many women had been manipulated by false arguments in favour of hospitalization and medicalization, and some obstetricians had been motivated by financial gain to steer women into hospital (Smulders and Limburg, 1985).

Midwives in private practice have contracts with hospitals which permit them to admit women. Many midwives have contracts with several hospitals and in any particular case use the one which seems most appropriate. We were told that contracts are not difficult to obtain and that few midwives are without them. Most home deliveries are conducted by privately practising midwives, although a very few are done by general practitioners, and some hospitals, like the one associated with the midwifery school in Amsterdam, allow their midwives to attend home births.

We visited what many describe as the leading private midwifery practice in Amsterdam. The midwives' practice includes complete pregnancy, childbirth and postpartum care, as well as some aspects of well-woman care, such as Pap smears. They perform blood tests for routine investigations, such as blood group, rubella and haemoglobin. They are not permitted to prescribe drugs, so that if a woman's haemoglobin is low and she needs iron, she must obtain a prescription for it from a general practitioner.

When the midwives attend home deliveries they take with them a well-equipped bag containing equipment for suction and resuscitation of the baby and episiotomy repair, and medication to prevent and stop postpartum haemorrhage. Typically, the woman calls her midwife when she is in labour and feels the need for her help. The midwife then goes to the woman's home to examine her and see how far the labour has progressed. If delivery is not imminent, the midwife likely will leave. She can be paged at any time by the woman. The midwives believe that a woman copes better with early labour if she is alone than if a midwife is hovering over her. The midwife stays with the woman during the later stages of labour and delivery. When delivery approaches, the midwife summons a maternity aide to be present at the birth and to remain afterwards. The midwife examines the newborn, but ongoing care is the responsibility of the general practitioner.

If the baby is delivered in hospital, the woman and baby are discharged within 36 hours of delivery. The midwife is responsible for postpartum care. She visits the mother and baby at home at first daily and then every second day, until 10 days postpartum. During the 10-day period the mother and baby are monitored by the maternity aide, who also assumes responsibility for housekeeping and care of other children. If the woman cannot be discharged within 36 hours, or chooses not to be, the midwife is not responsible for her postpartum care in hospital, and she is cared for by the hospital's nursing staff.

Midwives in private practice are able to provide almost complete continuity of care. They frequently work in small group practices of two or three midwives, and only infrequently will a woman be cared for by more than a small number of caregivers. The midwives have a great deal of autonomy and exercise a high level of responsibility. They are recognized as experts in the care of normal pregnancy and delivery. Because of this, we were surprised by their low rate of pay. The government's view is that a midwife in private practice should conduct about 165 deliveries a year (including all related pregnancy and postpartum care) in order to earn a reasonable gross income of about $30,000. This is considerably less than the gross incomes of $90,000 to $120,000 earned by obstetricians in private practice. Some midwives believe that it is impossible to provide good care to so many women, and have reduced their caseloads to about 100 deliveries a year.

We also had an opportunity to observe hospital based midwifery practices. There are different patterns of care at different hospitals. In some, midwives are involved in high risk as well as low risk cases, in others they are not. In hospital midwifery clinics, midwives provide pregnancy care and work in shifts on the labour and delivery floor. A woman is not usually assigned to a specific midwife, and little continuity of care appears to be provided. In hospital, as at home, labour is looked upon as a very natural process, and women in labour are permitted a great deal of freedom. The labour rooms we viewed in one hospital were clinical in appearance, with tiled floors and walls and no pictures on the walls. However, women were permitted to walk around, drink, and in some cases eat, and there were no routine enemas or shaves. Intravenous lines were rare. Women were usually permitted to deliver in any position they found comfortable. Although the labour and delivery areas lacked some of the physical comforts and adornments of home, we were not told of any pressure from consumers or midwives to make changes in the hospital environment or hospital practices. This may be because women have the option of delivering at home, or because the attitudes of caregivers in hospitals matter more than physical amenities.

Education

The Netherlands has three national training schools for midwives, located at Amsterdam, Rotterdam and Heerlen. Although 80 per cent of the curriculum is set by the state, there is some variation among the schools in their philosophical orientation. Each school admits 20 students per year, and the program lasts three calendar years regardless of the student's previous education. In particular, nurses are not given advanced standing or preferential admission. Students must have at least five years of secondary education, one year less than the six years required for admission to university programs. Applicants greatly outnumber the available places, and there is a rigorous selection process that includes a psychological assessment and personal interview. The objective is to select students who have intellectual ability, are well motivated, and are likely to be able to assume responsibility in practice. The selection process appears to be effective at least insofar as attrition is low.

The curriculum is mandated by statute and is directed to graduating from the program midwives capable of independent professional practice. We were impressed with the good marriage of theoretical and clinical training in the curriculum, but the scope of the curriculum struck us as narrow, little attention being paid to such subjects as the sociology of health and research methods.

Students are taught by midwives and obstetricians. Clinical education begins during the first year, with students observing deliveries and giving nursing care to mothers and newborns. During the second year, the students start to do deliveries under the supervision of a qualified midwife. At the end of the second year, students whose clinical work is satisfactory write an examination in obstetrics, paediatrics, physiology and gynaecology; they must pass this examination in order to enter the third year. During the third year, the students complete their theoretical and clinical education. They spend two to four weeks working in a private midwifery practice, attending home births. By the end of the third year, they must have conducted at least 40 deliveries. The final examination is oral. The student must examine a pregnant woman, make a diagnosis and prognosis, and outline her treatment. She must also discuss a complicated delivery and a paediatric case history.

We visited the midwifery schools in Amsterdam and Heerlen. The Amsterdam school has very liberal attitudes toward the birthing process. It is quite willing to experiment with such things as positions for delivery and does not stress the use of foetal monitors in routine cases. An obstetrician is the director of clinic services in the hospital with which the school is affiliated and also the head of the school. The faculty includes three obstetricians. A midwife carries out day-to-day administrative functions. The director of the Amsterdam school believes very strongly that midwives should not be "second class citizens" to physicians and take orders from them. She opposes general practitioners doing deliveries because of their lack of adequate training and experience. General practitioners in The Netherlands receive two months of obstetrical training during medical school and can graduate and obtain a licence having conducted as few as 15 deliveries. She prefers to admit students who are older than the minimum age of 19, and who have no prior nursing education.

The acting head of the midwifery school at Heerlen is an obstetrician well known for his opposition to planned home birth. At present the school is not affiliated with a general hospital, and its own midwifery service handles approximately 1200 deliveries a year. The school's orientation is considered to be much more conservative than the Amsterdam school. For example, the head prefers all women in labour to be monitored electronically. He believes midwives and general practitioners should conduct all deliveries in hospital. The school has five full-time staff midwives, who both run the prenatal clinics and conduct deliveries.

Conclusions

In reflecting on midwifery in The Netherlands, we were impressed by the pervasiveness of the view that birth is a natural process that requires the care of an obstetrician, someone trained in pathological obstetrics, only when a problem develops. The midwives are extremely well trained to care for physiological pregnancies, to conduct normal deliveries, and to detect pathology early. Both midwives and obstetricians understand well when referrals are to occur. There appear to be no "alternative" midwives practising outside the official health care system. There appears to be little problem when a midwife decides that a woman should deliver in hospital or should be transferred to an obstetrician; there is no resistance from the woman because she accepts that the midwife will transfer her only when it is necessary (Kloosterman, 1984).

We were interested to learn why and how the normal physiological view of childbirth has been preserved in The Netherlands, and why and how home birthing has been preserved. The reasons seem to be complex. One factor seems to be that the public, and pregnant women in particular, have a different attitude from that prevailing in North America; they take it for granted that normal, healthy babies will be born at home, and that anaesthesia and surgical procedures are unnecessary in most cases. There may be deeper cultural reasons as well. Dr. Kloosterman cites the strong influence of the Calvinist mistrust of human science, and The Netherlands' long history of being a place of refuge and a haven for different ideas.

It appeared to us that these attitudes have been protected and nourished by government policies and programs. The midwifery schools, which are nationally supported and regulated, graduate highly competent midwives who are able to manage healthy pregnancies and identify cases at risk with great accuracy. They feel confident about their ability to conduct home deliveries, and they know they can rely on the ambulance system and the goodwill of hospital midwives and obstetricians if the woman must be transferred during labour. The health insurance system discourages women from electing to be cared for by a general practitioner or obstetrician instead of by a midwife unless there is medical need, and encourages them to deliver at home. Hospital policlinics permit women to deliver in hospital and be discharged into the midwife's care within 36 hours. The maternity aide enhances the midwife's postpartum care, and makes home birth and early discharge attractive options.

It is wrong to think that the Dutch system is perfect in every respect. As we have pointed out, hospital midwifery services appear to offer relatively little continuity of care. Supporting midwives has added certain costs to the health care system, such as the 30 per cent duplication in payment resulting from women who must be transferred into the care of an obstetrician. The caseload the government expects a midwife to handle seems unduly high. We question the wisdom of requiring nurses to take the full three-year program to qualify as midwives. Overall, however, the Dutch system has many admirable features, and while some of them are inapplicable to the Ontario health care system, others might well be emulated.

Denmark

We included Denmark in our itinerary both to see midwifery practices and the Danish midwifery school, and also to visit the European Regional Office of the World Health Organization. We visited the School of Midwifery at Copenhagen and two maternity clinics located in the outskirts of Copenhagen. At the World Health Organization office we met with Dr. Marsden Wagner, Regional Officer for Maternal and Child Health, and Suzanne Houd, a Danish midwife who has served as research midwife for WHO.

Social Context

Denmark's population is approximately 6 million. Over 84 per cent of the population lives in urban areas, 25 per cent in Copenhagen alone. The standard of living is generally high, but unemployment is a major problem. Until recently, the Danish population was extremely homogeneous, there having been little immigration. This has changed in recent years, with the presence of immigrants, refugees, and guest workers from many countries. We were told that one in 10 women who delivers a baby in Copenhagen is from a non-Danish culture. In recent years, midwives in Copenhagen have begun to collaborate successfully with anthropologists to educate themselves about the birth customs prevailing in the cultures of origin of these women, and there seemed to us to be considerable willingness to accommodate those customs in the urban facilities we visited.

The birth rate in 1982 was 10.3 births per 1,000 population. Denmark has an excellent perinatal mortality rate, 8.4 deaths per 1,000 live births.

There are two schemes of medical insurance. One, which applies to 90 per cent of the population, provides free care by a general practitioner chosen by the individual; once chosen, this general practitioner cares for the patient for a year, at the end of which the patient may, if she wishes, choose another physician. Specialist care is available only on referral by the general practitioner. Under the second scheme, the individual can visit any general practitioner or specialist at any time. She pays the physician directly, and is reimbursed by the insurance plan for about two-thirds of the billed amount.

Organization of Care

Primary hospital and health care services, including midwifery services, are the responsibility of the county councils, of which there are 14, and of the council of the City of

Copenhagen. Most specialist services are available in each county and six regional hospitals provide highly specialized services. In each county and Copenhagen there are two to five midwifery centres, where pregnancy care is provided. There may also be small "out centres", which are usually staffed by a midwife one day a week. The purpose of the out centres is to minimize travel by pregnant women. There is a midwifery officer for each county, and each midwifery centre has a midwife-in-charge, and staff midwives. The midwifery officer is responsible for coordinating services throughout the county. The midwife-in-charge organizes the work of the staff midwives both inside and outside hospital.

In Denmark, 97 to 98 per cent of births occur in hospital. A woman may chose to be delivered in a minor hospital where there is no obstetrician in charge and the supervising doctor is a surgeon, or in the obstetrics department of a major hospital. Midwives connected with obstetrics departments travel to the minor hospitals for deliveries. Each county has at least one major hospital with an obstetrics department. A woman must deliver in her own county, unless for medical reasons she must be transferred to a hospital offering more specialized care.

Until the end of the 1950s, the organization of maternity care in Denmark was similar to that in The Netherlands, with official acceptance of home birth and independent, privately practising midwives caring for low risk pregnancies. Rates of obstetrical intervention were low. Government policy then shifted, and during the period 1960 to 1980 the percentage of hospital births increased from 50 to 99 per cent (Scherjon, 1986). All midwives became employees of the county councils in 1972, and the small maternity homes distributed throughout Denmark were closed in 1979. The motivation for the changes in the Danish system is not clear. They were not generated by unsatisfactory obstetrical outcomes or pressure from pregnant women. The changes appear to have resulted from the government view that hospital delivery is safer, the government's desire to economize by centralizing and streamlining care facilities, and perhaps a desire to impose greater central control.

Midwifery Practice

There are approximately 1300 working midwives in Denmark. Unemployment among midwives is a problem, especially in Copenhagen, as a result of a large increase in training opportunities in the 1970s.

A midwife usually divides her time equally between providing pregnancy care in a maternity centre, and attending births in hospital. Duty rosters are worked out in many centres so that a woman can see the same midwife throughout her pregnancy, and so that a midwife will not be on call the night before or the day she conducts a prenatal clinic. In hospital, it is more difficult to provide continuity of care and a woman will likely be attended at her delivery by a midwife other than the one who provided her pregnancy care. This midwife will probably be known to her from the maternity centre. Since the midwife must go off duty after an eight-hour shift, the woman may have two different midwives during the course of her labour and delivery. Midwives are permitted to conduct home births and there has recently been a slight increase in the demand for it. Prenatal classes are taught by midwives, who provide information, and physiotherapists, who teach exercises and breathing.

A woman may choose to obtain pregnancy care from her regular general practitioner, or any other, instead of a midwife. However, general practitioners are not permitted to conduct deliveries in hospital, although they may attend home births. A woman may not choose to receive primary care from an obstetrician, although she may, of course, be referred to one.

Danish midwives play a limited role in the provision of postpartum care. Their role in this area was restricted during the time there was a shortage of midwives in Denmark. Nurses, who have no training in midwifery, provide most postpartum care, both in hospital and at home. We were told that the nurses' domination of postpartum care in hospital makes it difficult for midwifery students to obtain a well-rounded education. For their part, the nurses are said to resent their limited participation in births. Public health nurses or "health sisters" provide postpartum care in the home. We were told that relations between midwives and health sisters are generally good, but that many midwives would like to be health sisters but cannot unless they have nursing qualifications.

We visited the maternity department at a Copenhagen hospital and met with the chief midwife, and the obstetrician who is chief medical advisor. The pattern of care here seems to be typical of Danish midwifery.

The hospital has several labour and delivery rooms, and a parents' lounge. A spacious prenatal clinic, with room for mothers to socialize and children to play, is in another part of the hospital, as is the postnatal ward. Upstairs from the labour and delivery area is a perinatal unit for mothers and babies who have had obstetrical deliveries (for example, caesarean sections), and a gynaecology/surgery unit. Nurses, not midwives, assist at high risk deliveries in the perinatal unit.

The chief midwife is employed by the hospital while the staff midwives are employed by the county and work both inside and outside the hospital. Altogether about 29 full- and part-time midwives work at the hospital, for the equivalent of 17 full-time midwifery positions. There are head midwives in the delivery room and prenatal clinic each weekday morning and afternoon, and three shifts of two midwives each work in the labour and delivery area. Two midwives are on call as backup for labour and delivery.

A pregnant woman first visits the clinic at 14 weeks, after her pregnancy has been diagnosed by a general practitioner. At her first clinic visit, she will be physically assessed by an experienced obstetrician, and will meet a midwife. She will continue to be seen by a midwife at regular intervals and will also be seen once or twice more by her general practitioner. The woman's clinic appointments, which are 20 minutes long or longer if necessary, are scheduled on the same day each week to provide continuity of care. The midwife can consult with one of two obstetricians if she detects a problem, and if the obstetrician becomes involved in the woman's care, she will continue to see the midwife as well.

At the woman's first appointment she is told she can have a home birth, and if she so chooses, a midwife will visit her home about two weeks before the expected date of birth to see if it is properly equipped. At the time of the birth, the midwife will go to the home, equipped with a kit that includes suction equipment and oxygen for mother and child. Only two of the midwives at the hospital we visited attend home births; the rest lack the confidence to do them. There is also one physician from the hospital who will attend home births when necessary.

If there are complications, such as low birth weight or prematurity, the mother is delivered in the perinatal unit by an obstetrician. The normal deliveries are conducted in the labour and delivery area run by the midwives. The woman labours and delivers in the same bed. She is offered half an hour of foetal monitoring when she arrives at hospital, and there is no routine monitoring thereafter. There is no shave, the woman may eat, drink and walk around during labour, and she may be accompanied by her partner or another adult companion, and by her children.

Close to 20 per cent of women have some stimulation of labour, including five per cent whose labour is induced. Epidural anaesthesia is offered but very rarely used (two were administered in the year prior to our visit). Epidurals are administered by anaesthetists (who may not be available at night), and the medication in them is topped up by midwives. Half the women receive nitrous oxide ("laughing gas") during labour, and nearly everyone receives a pudendal block (a form of local anaesthesia) toward the end of labour. The episiotomy rate is 45 per cent, even though we were told the midwives try to avoid them. If during labour the midwife detects a problem, she will call the obstetrician but will remain with the woman until after the birth. The midwives deliver twins and breech presentations, the physicians perform the caesarean sections and vacuum extractions. The caesarean section rate at this hospital is 13 per cent; 7.9 per cent are acute caesareans, the rest subsequent caesareans or primiparous (first baby) breeches.

In the labour and delivery rooms midwives are assisted by nurses. It was our impression that the nurses function more like nursing assistants than registered nurses. We were told that the nurses think they and the physicians could do everything necessary for the women, and that the midwives are extraneous. The midwives, of course, think otherwise; they stress their different approach and the fact that they deal more with women's psychological needs.

The labour and delivery rooms at this hospital are not especially homelike, a feature which the midwives would like to change. During labour, the midwives encourage women to try different positions, and provide comfortable beanbag chairs for their use. One room has a whirlpool bath, which is used when the woman's cervix is five centimetres or more dilated, to promote relaxation and thereby to shorten labour.

The midwives rotate between the clinic and labour and delivery area and about 25 per cent of women delivering in the labour and delivery rooms know their midwife from the clinic. We were told that the major obstacle to continuity of care during labour is that the midwife must leave at the end of her eight-hour shift. The midwives would like to explore ways of letting women complete their deliveries with one midwife.

The mother and newborn usually stay in the labour and delivery room for about two hours after the birth. They are then transferred to the postpartum ward, where 98 per cent stay an average of five days. Rooming in (in which the baby stays in the mother's room instead of in the nursery) is the norm. On the ward all care is given by nurses. The woman's clinic midwife will visit her once. If the woman is discharged early (usually six hours after delivery), she will be visited by the labour midwife and the clinic midwife on the second and third days respectively. The woman's six-week postpartum examination is performed by her general practitioner and additional postpartum care is provided in her home by the health sisters.

We also visited the "ABC" or Alternative Birthing Centre at another Copenhagen hospital. At this service, labour, birth and postpartum care are all provided in the same unit and the midwives are involved in postpartum care. The environment is comparatively homelike, and the babies are dressed in regular clothes, not hospital garb. The service has insufficient beds to handle all the women who come in, and some must be assigned to the regular obstetrical ward.

Education

Denmark has one school of midwifery, operating two sections, at Aalborg in Jutland and at the State University Hospital in Copenhagen. The Copenhagen branch was 200 years old in 1986; the Aalborg branch opened in 1979. The Danish Ministry of Education gives the school its budget and has laid down the curriculum. Each section of the school has a midwife-in-charge and an obstetrician who is regarded as the head. A schools board, with representatives from both sections, the

Ministries of Health and Education, and the Danish Midwives' Association, is responsible for curriculum changes. In each section, an education board with faculty and student representation makes local decisions about the syllabus, curriculum and examinations; however, Ministry guidelines must be followed and consistency maintained between the two sections. The head of the school reports to the Ministry of Education. The school is not affiliated with a university.

Each section of the school admits two "intakes" of 10 students per year, in October and April. The class size was reduced recently, and the full-time teaching staff cut, because of the oversupply of midwives in Denmark. There are 800 to 1000 applicants each year for the 40 places. The applicants are sorted into four groups, and a percentage of places is allotted to each group. Thirty per cent of places are allotted to the students with the best academic records. Fifty per cent are allotted to students who meet university entrance standard and have one year of relevant experience, such as work as an auxiliary nurse. Fifteen per cent are allotted to students who do not meet university entrance standard, but have 10 years of education and at least two years of work experience. The remaining five per cent of places are allotted to students who are not Danish nationals but have resided in Denmark for at least two years. In contrast to the Dutch admission process, in which applicants are interviewed and psychologically assessed, in Denmark no interviews are conducted, and the students are selected from each group by lot.

Nurses may apply, and if accepted they are admitted into the second year of the program after a two-week preliminary course. Only a minority of students are in fact nurses.

The average age of the students is 25, and many have families by the time of graduation. One student in 10 does not complete the program. The composition of the class is quite mixed because of the admission criteria, and we were told that this tends to make teaching more difficult. Tuition is free, and second and third year students currently receive a stipend equivalent to 50 to 60 per cent of a midwife's salary. We were told that the stipend is to be discontinued because the Ministry of Education now faces the additional expense of paying the counties for placing students in their hospitals and supervising them.

The school has a faculty of six full-time teachers. All the teaching midwives have several years of practice experience, and have completed a one-year course in teaching and administration run by the Ministry of Education. The school relies heavily on additional part-time teachers. Only academic subjects are taught by the faculty at the school. Clinical teaching is provided by midwives at the hospitals where the students are placed.

The program lasts three years and focusses on pregnancy care and labour and birth. Each year contains classroom and clinical components. During the first year, after a 20-week course on basic science and the theory of normal midwifery, the students write an examination. If they pass, they move on to spend eight weeks in the labour ward and four weeks in each of the prenatal clinic, medical ward, surgical ward and postpartum ward. The student's work in each area must be satisfactory before she can proceed to the second year. During the second year, students begin to apply the theory they have learned, and study new subjects including obstetrical pathology, diseases in pregnancy and neonatal paediatrics. They obtain 15 weeks clinical experience on the labour ward and five weeks on each of the prenatal clinic, neonatal ward, postpartum ward and gynaecology ward. At the end of the second year there is an examination. During the third year, the theoretical education is completed, and students are taught the organization of Denmark's social and health services, social legislation, and regulations governing midwives' work. They obtain a further 15 weeks clinical experience on the labour ward and five weeks on each of the prenatal clinic, prenatal ward, postpartum ward and in a midwifery centre.

Overall, during three years the students spend 14 weeks in the prenatal clinic, 10 weeks on the prenatal ward, 38 weeks on the labour ward, nine weeks on the postpartum ward, five weeks in gynaecology, and eight weeks on the medical-surgical ward. In order to graduate they must deliver at least 40 babies, and pass a final examination which is mostly written but includes a 20 minute oral section. All the students usually pass. Upon graduation, the student receives a certificate which enables her to be licensed by the National Board of Health.

The school itself has no midwifery clinic or service. Students are placed in the obstetrical departments of teaching hospitals and at smaller hospitals in the area around the school. To be selected as a clinical teaching site a hospital must have sufficient numbers of births. At the hospital clinics, the midwife in charge is responsible for the students. Since 1985 each hospital has had an instructor midwife who is responsible for liaison with the school. We were told that the school's separation of classroom and clinical teaching is a disadvantage. It is felt that the classroom teaching is the poorer because of it, and that the teachers lack credibility with students and practising midwives because they do not practise.

Denmark has no advanced midwifery education except for a Ministry of Education program on teaching and administration. Despite this, a number of midwives are engaged in research and some offer research workshops at continuing education programs. The Danish midwives we interviewed feel that it is important for midwives to do research so that midwifery's unique perspective and approach will be preserved. Danish midwives are required by law to keep up-to-date, but no mandatory program is laid down. A midwives' organization, Den Almindelige Danske Jordmoderforeming (DADJ) runs courses on selected topics (Newson, 1981).

Trends in Danish Midwifery

We were told that some Danish midwives fear for the future because of limitations being placed on their scope of practice and increased use of technology. The routine use of foetal monitoring and ultrasound appears to be particularly contentious among midwives. We noted that routine foetal monitoring was fully accepted by the head midwives of the two clinics we visited, even at the Alternative Birthing Centre.

A comparison of trends in care in Denmark and The Netherlands, recently published in the *British Journal of Obstetrics and Gynaecology* (Scherjon, 1986), demonstrated that the rate of obstetrical interventions increased markedly during the period 1960 to 1980. The total rate of operative interventions increased from about four per cent to almost 20 per cent in Denmark, and the rate of caesarean section increased from two per cent to 11 per cent. These increases are much greater than those that occurred in The Netherlands, where the total rate of operative interventions is now 12 per cent, and the caesarean section rate is four per cent. The increases in intervention rates coincided with the changes in the organization of care already described and the move to total hospitalization of birth. In both Denmark and The Netherlands, there was continuous improvement in perinatal mortality, but the improvement was greater in Denmark because of greater improvement in neonatal mortality. The author of the article suggests that this improvement was not due to phasing out planned home birth, but rather resulted from phasing out small clinics and hospitals that were ill equipped to handle real pathology.

New national Guidelines for Pregnancy Hygiene and Perinatal Assistance (reproduced in Appendix 5) are a major source of renewed optimism in Denmark. The Guidelines were issued by the government in March, 1985, replacing an earlier set of guidelines. In their preparation there was unprecedented consultation with women's organizations and midwives, and the Danish Institute for Clinical Epidemiology conducted a national survey of the actual experiences of women. The consultation process was fuelled by a conference on birth held in 1983 by the Danish midwifery and obstetrical organizations and WHO. The conference, which was extensively reported on by the Danish news media, highlighted the controversy between the "high tech" and health promotion approaches to birth (Houd, 1986).

The Guidelines emphasize that pregnancy, labour and birth are a continuous, natural process. They state that the woman should have as much influence on her pregnancy and birth as possible and she should take part in decisions about the place of birth and the use of equipment. The place of birth should be chosen with regard to maximum safety and security, and steps should be taken to ensure that necessary contact is made, and confidence established, with the personnel at the birth location. The Guidelines also emphasize the role of the general practitioner in coordinating the health care team; the team's responsibility is to support the woman throughout pregnancy through regularly scheduled check-ups. The woman should receive preventive health examinations from one midwife or a small team of midwives, who come to know her well. Wherever possible, one of the midwives from the small group should be present at the birth. Other caregivers, such as social workers and physiotherapists, should be called in when necessary.

The Guidelines stress the need for collaboration between the general practitioner, who is described as "the key individual at the beginning of pregnancy in respect of diagnosis and the referral to midwife or specialist based on the initial health examination" and the midwife, who is described as "the professional in closest contact with the pregnant woman and ... the key professional during delivery". The Guidelines state that the woman should be free to choose her place of delivery from a variety of locations: a hospital obstetrics department, a hospital surgical department (where available) where she can be supervised by midwife, a maternity clinic with a delivery room (where available), or home. Outpatient delivery should be available at all hospital facilities.

The Guidelines are not legally binding on the counties, but are extremely influential. They are providing an opportunity for experiments in different patterns of care, such as "mini-centres" where a small group of midwives takes care of all births in a geographically defined catchment area. The consultation process that went into their preparation has continued, with groups of midwives and obstetricians meeting on a regular basis to discuss issues in the management of perinatal care.

Conclusions

If the objectives of the Guidelines are achieved, maternity care in Denmark may become a model of individualized care within a highly institutionalized birthing environment. It will be interesting to see whether the health promotion philosophy manifested by the Guidelines will result in reductions in the rates of surgical interventions in birth, and whether the incidence of home birth will increase. The Guidelines hold promise for midwives and their ability to be leading professionals in the provision of care. For consumers, they offer much greater freedom of choice in both caregiver and location of care, as well as the promise of increased continuity of care.

United Kingdom

Midwifery in the United Kingdom presents many interesting contrasts to midwifery in Denmark and The Netherlands. The first contrast is size: there are approximately 30 times the number of practising midwives in the U.K. as there are in Denmark or The Netherlands, and in England alone there are 145 midwifery educational programs. Another striking contrast to both Denmark and The Netherlands is that the vast majority of U.K. midwives enter the profession through nursing, although it is permissible to enter directly.

The Task Force visited the statutory bodies which regulate midwifery, midwifery practice settings both in and out of hospital, and the mainstream and alternative professional organizations for midwives. We met with leading perinatologists and midwifery researchers. Our visits were mainly in England, but we also went to Scotland and Wales. We also read the scholarly literature on the development of British midwifery (Ehrenreich and English, 1973; Donnison, 1977; Rich, 1976; Anisef and Basson, 1979; Ward, 1981; Bent, 1982; Robinson, 1983).

Historical Development of Midwifery in the United Kingdom

Many Canadians have had contact with British midwives, either as users of their services or as colleagues in medicine and nursing. It may surprise them to learn that although midwifery has been a distinct profession in Britain for several centuries, it has been embattled for much of its history.

In Britain, as elsewhere, the development of the predominantly male medical profession had a major impact on midwifery. Before the 13th century in England, medical practice was open to everyone, regardless of training or education. A form of regulation began in the 13th century with the development of barber-surgeon guilds. In return for guaranteeing standards of entry, training, and practice, members of the guild were granted exclusive rights to practise and the right to prosecute unauthorized practitioners. English physicians campaigned for laws to get rid of female healers, who sometimes became the victims of witch trials. It has been estimated that 85 per cent of those executed after witch trials were women and children; the crimes of the women included providing contraception, performing abortions, and giving drugs to ease the pain of labour.

The first national regulation of medical practitioners came with the Medical Act of 1512. The Act applied to midwives and thus gave their profession a measure of legitimacy and recognition. It was administered and enforced by local church authorities who would grant the applicant a licence to practise in the diocese upon proof of good character and the taking of an oath not to use sorcery. Midwives were expected to be mature, married women with children of their own. Many 16th century midwives were well educated, and had lucrative practices. During the century they made three unsuccessful attempts to obtain a charter for a midwifery craft or professional organization. In this they were opposed by the physicians.

The term "man-midwife" first appeared in the 17th century. Caring at first only for difficult cases, man-midwives began during the 18th century to take over the upper class patients who were able to pay good fees. The invention of obstetrical forceps around 1720 gave man-midwives an advantage over women midwives who were prevented from using forceps by law, custom, and lack of instruction. The establishment of lying-in hospitals for the London poor during the second half of the 18th century provided man-midwives with women upon whom they could obtain experience in normal midwifery. The persecution of midwives in earlier centuries had stigmatized them as superstitious, and even malevolent, and this hindered them in their unsuccessful defense of their sphere from incursions by the man-midwives.

During the 19th century midwives fell further into disrepute. Since physicians monopolized the better paying patients, midwives worked primarily among the lower classes. While in earlier times midwives were often from the upper classes and were relatively well educated, now they were mainly from the lower class, and many of them were untrained.

In 1869, an investigation by the Obstetrical Society of London into the causes of high infant mortality laid the blame on inadequately trained midwives. This led the Society to establish an examination for midwives; successful candidates were awarded a diploma. Control of midwives was granted to the General Medical Council, a body established in 1858 to regulate licensing and educational facilities for physicians and to keep a central register of practitioners. The last three decades of the 19th century witnessed many attempts by midwives to obtain professional autonomy. A group of well-educated midwives formed the Matron's Aid Society, which later became the Midwives Institute and developed into the College (now the Royal College) of Midwives. During the 1880s and '90s many bills providing for the registration and training of midwives were introduced in Parliament, but not passed.

As the nineteenth century drew to a close, the struggle between midwifery's supporters and its opponents was inflamed. A report in 1893 by a select committee of the House of Commons attributed a large number of maternal and infant deaths to the inefficiency and incompetence of many women practising as midwives without proper training and qualifications. It reported frequent misuse of drugs and gin, and substantiated allegations of manslaughter against midwives and claims that midwives sometimes refused to send for a physician in complicated cases for fear of losing their fees. The committee recommended registration of midwives as a solution to these ills.

The recommendation was strongly opposed by the majority of physicians. They argued that a Midwives Act would merely legalize irregular practice by the very people who were responsible for the high rate of infant and maternal mortality. It would create a new class of medical practitioner, which would confuse the public. Conversely, it was argued that the prohibition of midwifery by unqualified persons would discourage the "friendly neighbour" who, however unqualified, was often the only person available to attend a confinement, especially in rural areas. All kinds of objections were raised: regularizing midwifery would increase the incidence of abortion and it was merely a device to increase employment opportunities for women. Women physicians feared the public would not be able to distinguish between them and midwives, and feminists opposed any bill which aimed to treat women separately, and to subject midwives to the control of men physicians. Various solutions to the "midwife problem" were advanced, including the impractical proposal that the few women physicians then practising in Britain should be entirely responsible for obstetrical care. The Royal British Nursing Association supported the proposal to create a new class of obstetric or midwifery nurses.

However, public opinion was increasingly in favour of registration of midwives. The cause was advanced by a well-publicized tragedy: unable to handle complications that arose during a confinement, a midwife had sent the husband to seek help from three local physicians. All three physicians refused to attend on the ground that they would not "follow" midwives. Both mother and infant died. Public animosity to the medical profession strengthened the hand of the sponsors of the midwifery bill, who now proposed that midwives should not be subject to control by the General Medical Council. The Government agreed, and a Midwives Act was finally passed in 1902. The Act was followed by similar legislation in Scotland in 1915 and in Ireland in 1918.

The 1902 Act created a Central Midwives Board, consisting of nine members, four of whom were physicians. No provision was made for midwife membership, but in fact three midwives were founding members. Not until 1920 was it mandatory to have four midwife members nominated by the Royal College of Midwives and two by the Secretary of State. Under the Act, certification was initially granted to any midwife who held a diploma from the London Obstetrical Society, or another recognized certificate, and who could provide evidence of good character and of bona fide practice for at least one year before. After 1910 an uncertified midwife could not attend childbirth "habitually and for gain" except under the direction of a physician. In 1921 the personal supervision of a physician was required for uncertified midwives, and they were finally absolutely prohibited from practising in 1936. The Central Midwives Board was charged with the responsibility of making rules for practice. Midwives were to be supervised locally through county councils and boroughs which were designated "local supervising authorities".

A Midwives Act passed in 1936 required local supervising authorities to provide the services of a certified midwife to every woman having a home confinement. As a result, the majority of self-employed midwives became salaried employees of the authorities, and unsatisfactory midwives were encouraged to cease practising. With World War II came increasing demand for hospital confinements because mothers had no one to help them at home. Because of the shortage of hospital beds, women were selected for hospital confinement on the basis of medical, obstetrical and social need. This, together with the fact that pregnant women obtaining regular care received extra food rations, encouraged attendance at prenatal clinics.

The establishment of the National Health Service (NHS) in 1947 had a great impact on midwives. With medical care now free, and physicians on the obstetric list paid additional amounts, women were encouraged to go to physicians, not midwives, for confirmation of pregnancy and for a decision as to whether they would have their confinement in hospital or at home. There was also an increase in the number of physicians on staff at hospitals, especially residents, and departments of obstetrics and gynaecology were established in all major hospitals. Midwifery was then taken over by the NHS, and midwives were employed on the same basis as nurses and health visitors (public health nurses). The midwives' work in the community continued to change as the number of hospital confinements increased, partly as a result of a series of government-commissioned reports that advocated hospital birth for reasons of safety. The number of practising midwives was felt to be grossly inadequate, and midwifery, and maternity services generally, again became matters of public concern and investigation.

Legislation passed in 1968 expanded the places of work permitted community midwives, as a result of which some of them became attached to general practitioners. General practitioners and midwives undertook pregnancy care in surgeries (physicians' offices), health centres, and local authority clinics, and they performed uncomplicated deliveries in hospital general practitioner units. In 1970, the Report of the Sub-Committee on Domiciliary Midwifery and Maternity Bed Needs, known as the Peel Report, made recommendations for the integration of maternity care services, including the employment of all midwives by a single service. The Peel Report also recommended that facilities be available for all births to take place in hospital in the interests of safety. In 1973 all midwives, whether based in hospital or in the community, were made employees of area health authorities.

Current Regulation of Midwives

The regulation of midwifery in Britain was restructured most recently in 1979 by the Nurses, Midwives and Health Visitors

Act. The United Kingdom Central Council (UKCC) and four National Boards for England, Wales, Scotland and Northern Ireland were created. The UKCC is responsible for maintaining registries of practitioners and for establishing and improving standards of training and professional conduct, while the National Boards are primarily responsible for training nurses, midwives and health visitors to UKCC standards. The UKCC and each National Board has a Midwifery Committee which must be consulted on all matters related to midwifery. The UKCC also has a full-time midwifery professional officer who can be directly consulted by any registrant about practice issues.

In 1986 the UKCC issued new Midwives Training and Practice Rules pursuant to the Nurses, Midwives and Health Visitors Act. These Rules, which apply to midwives in all parts of the U.K., replaced the sets of rules that were particular to England and Wales, Scotland and Northern Ireland. The UKCC has also issued a Code of Practice which complements the Rules and provides guidance in matters of practice. Midwives must also abide by the UKCC Code of Professional Conduct.

Education

The education required of midwives has been greatly extended over the course of this century. The 1902 Midwives Act required all midwives to take a three-month course of training regardless of whether they were trained as nurses. This was increased to six months in 1916, with two months remission for trained nurses. In 1926, it was further increased to one year, with six months remission for trained nurses. The structure of the program for nurses was changed in 1936. Henceforth, there would be two parts, Part I emphasizing theory and Part II emphasizing practice and including a minimum of three months of community experience. This structure was criticized on a number of grounds, and a unified program for nurses was re-introduced in the late 1960s. The most recent changes have come about because of the need to comply with the Directives of the European Community (EC) and the awareness that the existing program was too short to cover subjects in depth and to provide enough clinical experience. The program for nurses is now 18 months, and that for non-nurses or direct entrants three years.

Thus, both post-nursing and direct entry midwifery education programs have existed in tandem in the U.K. throughout the century. However, programs for nurses have always been much more numerous than programs for direct entrants, and there is currently only one direct entry program in England.

Each National Board has laid down a syllabus and has issued education guidelines. Curricula must meet UKCC standards, which in turn must comply with EC Directives. There are required numbers of hours for academic subjects and required numbers of clinical experiences of various kinds. The recommended teacher-student ratio is one midwifery tutor for every six to 10 students. Midwifery education programs in the U.K. are affiliated with hospitals but not with universities or colleges. Student midwives provide service in hospitals, where each student is counted as equivalent to one-half a qualified midwife. If they are qualified nurses, they are paid a nursing salary.

Each National Board is responsible for approving and monitoring the education programs in its jurisdiction. The English National Board, which has the largest number of programs to monitor, has six midwifery officers who regularly visit them. On the basis of the midwifery officer's report and recommendations and consultations with the Midwifery Committee, a decision is made whether to continue to approve a program, terminate its approval, or require it to make changes.

In addition to basic midwifery education programs, two other diploma programs exist. The Advanced Diploma in Midwifery is awarded by the National Boards after completion of approved course work and written and oral examinations. Two years of practice experience are required for entry to the program. The Midwifery Teacher's Diploma is awarded by the National Boards after one academic year of study. To teach midwifery, a midwife must have both diplomas.

British midwives are required to take a one-week refresher course every five years, and a midwife who has not practised for five years must take an approved refresher course lasting at least four weeks, and including practical and theoretical instruction. The Midwife's Code of Practice says the midwife is responsible for maintaining and developing competence, and she must ensure that she has received adequate preparation before practising new skills. The Royal College of Midwives publishes a quarterly Current Awareness Service which lists new papers, articles and books on subjects related to midwifery, and it is investigating providing distance learning through home videos and computers.

As was mentioned earlier, at present there is one direct entry midwifery education program in the U.K., accepting students with no preparation in nursing. A second program is slated to open in late 1987 or 1988. A larger number of direct entry programs operated in the past, but many were closed because it was felt that increased teacher requirements and the need to teach more subjects made them more expensive to operate. Currently, there is keen interest in expanding direct entry education in the U.K. The English National Board has asked all 13 regional health authorities in England to establish direct entry programs.

The argument in favour of direct entry education in the U.K. is that it is cost effective because the training covers only relevant subject areas and because rates of attrition from both training and practice are lower for direct entry midwives than for midwives who are also nurses. It is also argued that the three-year direct entry programs give students more time to develop skills. Direct entry is ideal for someone with no interest in nursing. On the other hand, the disadvantages are said to be that direct entry courses are still experimental, and direct entrants may lack medical knowledge. The career prospects of direct entrants may be poorer and it takes longer for them to be accepted as competent practitioners. The Association of Radical Midwives advocates that midwifery education be entirely by three-year direct entry programs; in its view, if midwifery were no longer an additional qualification for nurses, there would be less attrition or wastage through training people who have no intention to practise (Association of Radical Midwives, 1986).

The entire direction of midwifery education in the U.K., as well as education for nurses and health visitors, has been the subject of review by "Project 2000". Project 2000 was established by the UKCC three years ago in the exercise of its statutory responsibility to establish and improve standards for training. It issued a preliminary report in May 1986, and recommended that the existing pattern of education for nursing, midwifery, and health visiting be substantially changed. It recommended that preparation for registration as a "registered practitioner" begin with a common foundation program, lasting up to two years, followed by specialization in a branch. There would be five branches: adult nurse, child nurse, mental health nurse, mental handicap nurse, and midwife. However, it viewed inclusion of midwifery as a branch as experimental, and recommended that there continue to be 18-month programs after registration as a practitioner. It felt that the common foundation program route offered many of the advantages of direct entry midwifery preparation without its disadvantages (UKCC, 1986).

However, the Royal College of Midwives, which is both professional organization and bargaining agent for U.K. midwives, strongly objected to the idea of the "registered practitioner" replacing the midwife, and insisted that the title "midwife" be retained, with midwives registered separately from other practitioners. It objected to midwifery being treated as a branch within a three-year program, and argued that continuation of the 18-month program is essential. The RCM feared that there would be insufficient time in the program to develop midwifery skills to the necessary level of competency, and that the small number of midwifery students would be overly influenced by much larger numbers of nursing students. The ethos of midwifery would be submerged, and the profession might come to be viewed as a branch of nursing (Royal College of Midwives, 1986).

In its final report, Project 2000 abandoned the common foundation program as a route of midwifery preparation. However, it recommended that the potential for the sharing of courses by the common foundation program and the midwifery program be fully explored, a process which has not yet begun (UKCC, 1987).

Midwifery Practice

One of the problems of British midwifery which was acknowledged by Project 2000 was the high rate of attrition or wastage in the profession; that is, a relatively large number of people with qualifications in midwifery choose not to practise as midwives. This is another way in which British midwifery contrasts with midwifery in Denmark and The Netherlands.

One result of attrition is the generally acknowledged shortage of midwives in Britain. There is an official vacancy rate of 14 per cent over all established midwifery positions, but some observers say that the shortage is more severe and that a more realistic figure, considering actual workloads and working conditions, would be 35 per cent (Royal College of Midwives, 1985). The Royal College of Midwives believes that the salary scale for midwives is a major cause of the shortage, serving as a disincentive to recruitment and retention. Many midwives report that the shortage has reduced the quality of patient care and their own job satisfaction.

Of the UKCC's 1,500,000 registrants, approximately 30,000 are practising midwives and 9,000 to 10,000 are health visitors. The remainder, who make up the largest group by far, are nurses.

The majority of midwives work in National Health Service hospitals where they staff all parts of maternity services, including some nurseries and neonatal special care units. The minority of midwives, who are community based, make postpartum home visits, conduct parentcraft classes, and, to a limited extent, provide pregnancy care in general practitioners' offices. Midwifery services, like all health services, are organized by geographic region. Each regional health authority has a midwifery supervisor who is responsible for professional practice standards for all hospital and community midwives in the region. Every midwife must notify the midwifery supervisor annually of her intent to practise in the region. The midwifery supervisor is involved in disciplinary matters, and midwives have an obligation to inform her of questionable or potentially problematic situations.

The Midwives Rules outline the midwife's area of responsibility and scope of practice. She is responsible for providing midwifery care to mother and baby during pregnancy, labour, birth and the postpartum period. She is required to call a physician in emergencies and whenever she detects in the mother or baby "a deviation from the norm". The Code of Practice describes the midwife as a member of a team, and describes her responsibilities and those of physicians as "interrelated and complementary".

Midwives are permitted to obtain and administer certain controlled drugs, and community midwives may, subject to local rules, carry sedatives and analgesics, local anaesthetics, anti-haemorrhagic preparations and agents for neonatal and maternal resuscitation.

We visited the midwifery service at the John Radcliffe Hospital, the major teaching centre in Oxford. We met the midwife who is midwifery supervisor and director of community midwives, responsible for the deployment of 16 community midwives in the Oxford district. These midwives provide some pregnancy care within general practitioners' practices and rotate being on call for births of women from those practices. These deliveries take place in the hospital's "GP Unit". The midwives attend the 20 to 30 home births per year that occur in the district, most of which are planned home births, and make postpartum home visits to all new mothers in the district.

The midwives who are employed in the John Radcliffe Hospital, in contrast to the community based midwives, are assigned to consultant obstetricians. They do not have their own caseloads. Some provide pregnancy care and others provide care within the labour and delivery area, with the result that little continuity of care between the pregnancy and labour and birth periods is provided. One of the midwives' main functions in the labour and delivery area is teaching normal obstetrics to medical students and supervising student midwives. They also provide help and backup to the community midwives working in the GP Unit. A separate group of midwives staff the hospital's postpartum area and newborn nursery.

The pattern of staffing at the John Radcliffe Hospital appears to be typical of hospital maternity services in the U.K. There are very few obstetrical nurses as we know them in Canada, since nurses in the U.K. who wish to work in obstetrics must pursue midwifery training and qualify as midwives. Except within the GP Unit, there is little continuity of care through the pregnancy, labour and birth and the postpartum period, because of the allocation of midwives to specific areas.

There are, however, midwifery services in the U.K. which are organized differently. We visited one such service, the Sighthill Clinic in Edinburgh, where midwifery services were reorganized in an effort to improve obstetrical outcomes among a high risk population. A survey conducted between 1971 and 1973 revealed that Sighthill, a socially and economically disadvantaged area, had the fourth highest perinatal mortality rate in Edinburgh, at 27.9 per 1,000 live births. At that time, pregnant women had to travel to the University Hospital on the other side of the city in order to obtain pregnancy care, which was not offered by community based midwives. The dissatisfaction of these midwives with their role together with the evident need of the population resulted in the formation of a new service in 1976, operated as an outreach service of the obstetrical teaching service of the University of Edinburgh.

Since 1976 pregnancy and postpartum services have been offered at the Sighthill Health Centre which is located in a large housing development. Thus women can receive care close to home. Five general practitioners have practices there, and they provide comprehensive health services, including pregnancy care. Prenatal clinics operate on specified half-days of the week. Several obstetricians from the University of Edinburgh who helped establish the clinic and helped write the protocols for care which characterize it are available as obstetrical consultants.

Midwives working in the Sighthill Clinic cover the community for pregnancy care and postpartum visits. They do not, however, follow women into the hospital for delivery. The midwives do not have identifiable caseloads themselves, but work in association with the general practitioners; because they are not specifically assigned to any one practitioner, they may see any of the women who come in during pregnancy. There are three or four midwives available for pregnancy care during clinic times and others who are assigned to postpartum visits. Classes are conducted at the clinic by the midwives. Midwifery students are also assigned to the clinic.

The clinic has a laboratory, some diagnostic services and a small ultrasound unit, but referrals to specialized services and sophisticated tests require a hospital visit. The approach to pregnancy care is highly structured. The general practitioners and midwives follow the written protocols, which avoid the need for frequent consultations with an obstetrician.

On the day we visited the clinic, one general practitioner had scheduled appointments with approximately 15 pregnant women, some of whom were seen by midwives. When all the women had been seen the midwives and the general practitioners held a team meeting and discussed them. Health visitors were also present, and either a health visitor or a midwife was assigned to make any home visits that were necessary because a woman had missed an appointment or needed counselling. The team meeting also appeared to facilitate a measure of individualization of the protocols.

The Sighthill Clinic has succeeded in increasing the proportion of women who obtain care early in pregnancy, and in decreasing the percentage of missed appointments. The number of days of hospital admission for complications during pregnancy has been reduced, as have the rates for forceps delivery and caesarean section. The frequency of low birth weight, intra-uterine growth, retarded infants and admissions of babies to the special care unit has declined. However, it is not known what aspects of the clinic's services are responsible for the improvements. There is speculation that because the clinic is close to home and is comfortably designed, attendance at clinics has improved with the result that problems are detected earlier in pregnancy.

The job satisfaction of the Sighthill general practitioners and midwives is reported to be high, and we were struck by the great personal interest they take in women. While it is possible to criticize the clinic because its protocols allow little scope for individualized management, and because there is no continuity of care into labour and birth (hospital based midwives and obstetricians conduct the deliveries), the Sighthill Clinic is nevertheless a model of how midwifery services can be utilized to improve care and obstetrical outcomes among high risk women.

Midwifery services in various regions of the U.K. have been innovative in devising ways of organizing services in order to improve continuity of care. A small number of community based midwives conduct "domino deliveries" (domiciliary in and out), with the same midwife providing pregnancy care, conducting the delivery in hospital and providing postpartum care after early discharge. Midwives based at one hospital have devised a "Know Your Midwife" scheme, in which a small group of midwives provide care throughout pregnancy, labour, birth and the postpartum period.

The midwives who work in U.K. hospitals, as well as community based midwives such as those at the Sighthill Clinic, are all employees of the National Health Service. The U.K. has a small private health care sector, and it includes a few midwives who practise privately. Most are in the London area. They provide complete pregnancy, childbirth (home or hospital) and postpartum care, charging fees that range from about 400 to 700 pounds.

Current Trends in Midwifery in the U.K.

Many people are critical of the U.K. system of midwifery care. The critics have observed that the organization of services has tended to force midwives to specialize in one or two areas of care, and has sharply divided the areas of responsibility of hospital and community midwives. Continuity of care has been lost. With the closure during the 1970s of small maternity units, and the opening of large regional units, the responsibilities of midwives have been restricted. "Shared care" between obstetricians and general practitioners has tended to squeeze out the midwife's responsibility for assessing and caring for women during pregnancy. Obstetrical interventions have increased, and this has further enhanced the role of medical staff and diminished the role of the midwife.

Concern over the narrowing role of the midwife led the Nursing Research Unit of Chelsea College, University of London, to conduct a national survey of midwives, health visitors, obstetricians and general practitioners (Robinson et al., 1983). The survey disclosed that the responsibility of midwives for clinical assessment of pregnancy has been substantially diminished and that physicians are overly involved in assessment of normal pregnancies. Most community midwives have little involvement with labour and birth, and a substantial proportion of hospital midwives work in units in which decisions relating to management of normal labour are not made by the midwife, but are dictated by medical staff or unit policy. The continuing emphasis on potential abnormalities and the focus on the roles of obstetricians and general practitioners have militated against midwives having full responsibility for normal cases. Staff shortages and large amounts of clerical work have also prevented midwives from forming supportive relationships with women. The study concluded that except in the area of postpartum care, where community midwives have retained an active, independent role, care has been fragmented and midwifery training and skills are being wasted. Public confidence in midwives has been undermined.

An American observer who studied midwifery in Britain and six other European countries in the late 1970s, wrote:

> ... the English midwife, once the essence of midwifery, no longer carries the status of an 'independent practitioner in her own right'. Not only are English midwives primarily hospital employees, but they have been relegated to a specific area of maternity care. They work either in prenatal care, labour and delivery, or postnatal care. Some hospitals try to rotate their staffs to keep them current on all three aspects of care, but this is not the norm. Similarly, community midwives primarily focus on postnatal care and to a lesser extent on prenatal care. Only occasionally are they permitted to do a delivery.
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> The prenatal responsibilities of the English midwife are very limited. They consist only of history taking, measuring height, weight and blood pressure and doing a urinalysis. All other aspects of the examination are carried out by a doctor. The mother has little or no chance to talk with the midwife and rarely has more than few minutes time with the doctor...
>
> Midwives working in labour and delivery are actually in charge of the normal pregnancies. The midwife is still the senior person present in approximately 76% of all deliveries. However, midwives have little say in hospital policy, which is determined by doctors and administrators... (Willett, 1981)

The Association of Radical Midwives, an organization of approximately 800 to 900 midwives, believes that the organization of midwifery services must be substantially changed. It has outlined its views in a publication called *The Vision* (1986). The Association advocates a system in which within 10 years 60 per cent of midwives would be based in community practice, with full scope of practice and the ability to do deliveries at home or in hospital. These midwives would be organized in teams of up to seven midwives.

The Royal College of Midwives, too, is concerned about the diminished status and narrowed role of the midwife. It attributes midwifery's current difficulties to several factors, most importantly the fragmentation of maternity care within the National Health Service, the trend toward greater medical and technical intervention in normal pregnancies and confinements, and inadequate staffing. The RCM strongly believes that midwives should receive a pay differential above nurses' salaries, in reflection of their special role and responsibilities (Royal College of Midwives, 1984; Hill, 1985). This position has so far failed to carry the day. The RCM has recently issued a report that focusses on direct entry educational preparation, and its officers have spoken publicly about the need for the midwife to reclaim her autonomy (*The Times of London*, Feb. 19, 1987).

It was our impression that many British midwives are uneasy about the post-1979 structure of governance, in which they are grouped together with health visitors and the very large number of nurses. Some of their uneasiness has to do with difficulties in advancing midwives' particular interests in relation to pay and working conditions, but there also appears to be some feeling that the structure works against reinforcing the role and status of the midwife and midwifery's identity as a profession separate from nursing.

As in North America, several consumer organizations, such as the National Childbirth Trust, the Association for Improvements in Maternity Services and the Active Birth Movement, are working to improve maternity care. In 1986 there was fierce public debate culminating in a march by some 1500 women demanding the reinstatement of a London woman obstetrician, Dr. Wendy Savage. Dr. Savage had been suspended following charges of malpractice in the management of five pregnancies. She favoured natural childbirth if at all possible, avoided routine technical interventions, and believed in the woman's right to choose the type of birth. All charges against her were ultimately rejected by an independent tribunal. Dr. Savage wrote a book about her experiences, entitled *A Savage Enquiry*. Her ordeal sharpened considerably the debate about "high tech" versus natural deliveries.

As far as we could determine, the dissatisfaction of consumers with midwifery care under the National Health Service has not led to the creation of alternative services, such as those offered by North American midwives. However, the small number of midwives practising privately represents an alternative at least to the National Health Service.

Place of birth remains controversial in the U.K. even though only about one per cent of deliveries are in the home and only two-thirds of these are planned home births. The Chelsea College study mentioned above found that 45 per cent of the midwives, obstetricians, general practitioners, and health visitors it surveyed had conducted no home deliveries, and the majority of the 55 per cent who had, had conducted five or fewer. Another study has documented the decrease in numbers of calls to the well-known "flying squads" which have been used to assist in home birth emergencies (Ryan and Kidd, 1987). Slightly more than half the midwives surveyed in the Chelsea College survey expressed willingness to do home deliveries in low risk cases and another 29 per cent said they were willing if the mother insisted. The midwives said they were prevented from doing more home deliveries by the reluctance of general practitioners to provide back-up, local policies against home deliveries, and the lack of sufficient midwives to provide adequate service.

The Midwife's Code of Practice provides specific guidance in relation to home births. A midwife attending a woman having a home birth is instructed to ascertain whether or not a physician is available to attend if required. If a physician is not available, the midwife must inform her supervisor. If the midwife believes home birth is inappropriate in a particular case, but the woman refuses to take her advice to give birth in hospital, the midwife must continue to give care and inform her supervisor. Similarly, if the midwife believes a woman booked for a home birth may require medical assistance, but she or her partner refuses to have a physician in attendance, the midwife must continue to care for the woman and inform her supervisor. It is the supervisor's responsibility to ensure that there are agreed local policies to support the midwife in these situations, so that the best possible arrangements can be made for the woman and baby.

Our own observations in the U.K. tended to confirm the criticisms of midwifery services there. It seemed to us that the organization of care, in which services are primarily hospital-based and midwives are assigned to work in a specific area, and not to care for women throughout pregnancy, delivery and the postpartum period, was responsible to a significant degree for the narrowing of the midwife's role and the diminution of her responsibility. The restrictions on her role partly account for low morale and job dissatisfaction among midwives, and these in turn appear to lead to a high rate of attrition from the profession. From the mother's viewpoint, most conventional midwifery services provide very little continuity of care, and it was our impression that the style of care is often impersonal.

The profession is making valiant efforts to restore midwifery to a role of full responsibility and autonomy. It will be interesting to see if its efforts can succeed in the face of powerful organizational stresses.

International Trends in Midwifery Services and Reproductive Care

The features of reproductive care and midwifery services that we have described in the United States, The Netherlands, Denmark and the United Kingdom exemplify trends that cut across national boundaries.

Having a Baby in Europe, a report published by the World Health Organization in 1986, traces the evolution of reproductive care over the past several decades.

Pregnancy Care

Pregnancy care has changed in several ways. First, the location of care has changed, with the woman visiting the caregiver instead of the converse, and with the visit taking place in a hospital clinic instead of in a neighbourhood setting. The significance of this change is that a basic, preventive service has been moved from a primary health care setting in the community into a secondary setting. Second, the capacity to identify and refer women with abnormalities in their pregnancy has evolved into the capacity to identify and refer women *at risk of developing* abnormalities. Because the system depends on risk prediction, while at the same time much abnormality has remained unpredictable, there has been a tendency to define more and more risk factors, with ensuing implications for care. Risk assessment has focussed on clinical factors, to the near exclusion of social factors such as poverty, with the result that few services address the psychological and social needs of pregnant women.

Third, continuity of care is rarely provided, and pregnancy, birth and the postpartum period are usually regarded as three clinical situations requiring different expertise, personnel and clinical settings. According to WHO, the lack of continuity of care is the most frequent cause of complaint in studies of consumer satisfaction with care. Fourth, the pregnant woman generally has little to say in determining who will care for her, where she will be cared for, and what the care will consist of.

WHO notes the implications for the content of care of these structural characteristics. Most notably, risk screening of all pregnancy women is extensive and steadily increasing. Because risk screening sometimes involves high technology, women must be brought into hospital. The health care specialists who work in high technology settings become overwhelmed by the volume of normal women. The number of "false positives" increases because the diagnostic tests have been applied to all women. For the woman with a false positive, the consequences may be increased anxiety and still more diagnostic tests and procedures.

To universal risk screening is coupled the pressure to "do something" when an abnormality is detected or suspected. This pressure has led to the use of protocols, procedures and drugs that sometimes have received little or no prior evaluation. Sometimes they continue to be used even after they have been proved to be of no benefit. For example, restricting weight gain during pregnancy to less than twenty pounds has been proved to be of no benefit.

These changes in the content of care have affected caregivers, particularly midwives. According to WHO, over the last 50 years there has been a gradual decrease in the midwife's role in pregnancy care, and a corresponding increase in the role played by physicians. General practitioners, too, have been affected as the role played by obstetricians has expanded, even in uncomplicated pregnancies.

Childbirth Care

Care during birth has been profoundly altered as well. WHO makes the compelling point that with nearly universal hospitalization of birth, most caregivers have no experience with "non-medicalized" birth, or have forgotten what it is. That is, they have limited knowledge of the nature of birth without medical intervention. One result of this is that they have no genuine yardstick by which to measure the results of intervention.

Most European countries have moved toward rationalizing services on a regional basis, with three levels of care. But despite the objective of restricting use of secondary and tertiary level services to women who truly need them, in fact, in most countries more births are taking place in the larger hospitals. Except in The Netherlands home birth has been discouraged, with the result that in most developed European countries, the rate of home birth is less than five per cent.

In hospital, the woman is usually subjected to an enema and shave, procedures which have not been proved to be of any value. There is a trend toward more frequent induction of labour (starting labour artificially with drugs), and the use of drugs to relieve pain in labour is widespread. In the majority of countries surveyed by WHO for its report, the woman is given a choice about pain relief, but the choice is rarely informed because the woman is given little or no information about the risks and side effects. WHO describes the widespread use of electronic foetal monitoring before proper evaluation as "a model of the inappropriate application of technology", and says monitoring is partly responsible for the dramatic increase in the caesarean section rate in many countries. In only one-third of the countries surveyed for the report are women given a choice about monitoring. Rates of episiotomy, caesarean section and operative delivery (delivery with forceps or vacuum extractor) vary considerably, and in WHO's view "cannot be explained by differences in women in these countries, but must rather represent differences in medical practice".

The medicalization of birth and the movement into large hospitals have resulted in physicians assuming responsibility for all births. Midwives have been transformed into physicians' assistants. The skills of both midwives and physicians have shifted toward technology, at the expense of clinical skills involving direct patient contact. For example, with the widespread use of electronic foetal monitors, midwives tend to lose the skill of evaluating the quality of foetal heart tones, and they may sit at desks monitoring the machines instead of sitting at the bedside. When midwives are assigned to work shifts in hospitals, they are unlikely to be present throughout a woman's labour and delivery, with a resultant loss in continuity of care.

Postpartum Care

In Europe, with some exceptions, pregnancy, labour and birth are the domain of the obstetrician and midwife, while postpartum care is the domain of the paediatrician and paediatric nurse or home visiting nurse. In some, but not all countries, the midwife plays an important role with the mother after birth. In general, there is little communication between the prenatal and labour and birth caregivers on the one hand, and the postpartum caregivers on the other. In WHO's view, postpartum health care resources are being allocated inappropriately, with most resources being applied to secondary and tertiary care for the minority of babies who are very sick, while few resources are devoted to the majority who are well or nearly well. At the most critical times in the infant's life, the least trained caregivers may be present. For the mother, postpartum care that addresses the social aspects of health, as opposed to obvious physical needs, is largely non-existent. At the same time, newborn intensive care is often insufficiently defined and planned.

There are bright spots in the generally gloomy picture of care painted in *Having a Baby in Europe*. In several countries there is vigorous debate over the use of technology in childbirth and public concern over rates of caesarean section and operative delivery. Routine hospital procedures are being reconsidered. Eight of 10 countries surveyed by WHO are experimenting with liberalizing the permitted positions for delivery, and are reviewing their episiotomy practices. Rooming-in of babies with their mothers after birth is widely available, and routines in newborn nurseries are becoming more flexible. Indeed, WHO predicts that with the popularity of rooming-in and the rise of early discharge programs, nurseries for healthy newborn babies may become a thing of the past.

The European Regional Office of WHO has been actively involved in efforts to "de-medicalize" birth, or at least to restrict the use of technology to appropriate cases. It has published guidelines on the appropriate use of technology in and after childbirth. It has co-sponsored or helped to organize conferences on reproductive care in a number of European countries. Its Director of Maternal Health, Dr. Marsden Wagner, is a vocal advocate for midwifery both in Europe and North America.

The crisis for midwifery caused by the nature of modern reproductive care is very clear in the U.K., where the extent to which the midwife's role has been diminished has been revealed by the Chelsea College study. The Association of Radical Midwives has presented its vision of what midwifery services should be like and various consumer organizations are attempting to humanize reproductive care. The Royal College of Midwives is outspoken. In Denmark, new perinatal guidelines are an expression of the government's will to restore continuity of care and give women greater freedom of choice over place of birth and the content of their care.

In other developed countries, such as Australia and the United States, midwives' associations and consumer support groups are campaigning for greater recognition and support for midwives as autonomous practitioners. Finally, in almost all these countries, the idea that home is a legitimate place for birth has survived, despite the fact that 95 per cent or more of deliveries take place in hospital.

Chapter 3

THE CURRENT SYSTEM OF REPRODUCTIVE CARE

Purpose of the Chapter

In this chapter we describe the existing system of reproductive care in Ontario: the system's structure, the providers of care, the places where care is provided, and how care is paid for. In addition, we discuss how well the system works: its success in caring for women and their satisfaction with the care they receive.

The chapter provides the context for the Task Force's consideration of the issues and recommendations. We hope it will be especially useful to readers not familiar with the system.

The chapter begins by discussing the structural aspects of the Ontario health care system that most impinge on the provision of reproductive care.

The Role of Government

Health care in Canada is the responsibility of each provincial government. The Government of Ontario discharges its responsibility in a number of different ways. It regulates many health professions. Provincial legislation lays out the framework for the incorporation and operation of hospitals. Provincial control over funding of health care shapes the content and quality of care. Provincial funding of post-secondary educational institutions affects the kind and number of health professionals produced in Ontario.

The Professions

Autonomy

The Government establishes the legislative framework within which the professions govern themselves.[1] Medicine, dentistry, nursing, pharmacy and optometry are governed under the *Health Disciplines Act*, while other health professions are governed under a variety of statutes and regulations. Although this legislation reserves important regulatory powers for the Government, it gives each profession substantial autonomy. The professions regulated under the *Health Disciplines Act* have significant autonomy even in such critical matters as educational requirements for entry to the profession and standards of practice. Each profession's governing body is responsible for investigating complaints against individual members and for disciplining members guilty of professional misconduct.

The Ministry of Health consults regularly with the governing bodies of the professions and with the various professional associations.[2] Ministerial committees, such as the Advisory Committee on Reproductive Care, include leading members of the professions.

Because of the substantial autonomy exercized by the professions, and the role they play in health care institutions, it is difficult, though certainly not impossible, for the Ministry to bring about change in the system without their cooperation.

Licensure and Registration

Licensure and registration are both ways of regulating professional practice. If a profession is regulated by licensure, only a person licensed by the body that governs the profession may practise lawfully and use the titles restricted to the profession. Medicine, dentistry, pharmacy and optometry are licensed professions in Ontario. If a profession is regulated by registration, a person whose name does not appear on a register maintained by the governing body may practise lawfully but may not use the titles restricted to the profession. Nursing is a registered profession in Ontario, not a licensed profession. It is lawful to practise nursing in Ontario without being registered, but only those who are registered may call themselves registered nurses and registered nursing assistants and use the designations R.N., Reg. N. and R.N.A. In fact, the great majority of nurses in Ontario are registered and it is virtually impossible to obtain hospital employment without being registered (except during the brief period between graduation from nursing school and initial registration).

In both licensure and registration systems, the governing body sets and enforces educational and practice standards for the practitioners under its jurisdiction.

Over the years there has been considerable debate over whether licensure or registration better serves the public interest. Invariably, the professions prefer licensure because it confers on them a monopoly over the occupation, while economists and other critics argue that the public is better served by the more open registration system. The distinction between the two is often confusing, and is now under review by the Health Professions Legislation Review as part of its comprehensive study of Ontario's health professions legislation.

Hospitals

Relationship to Government

Hospitals are incorporated under the *Corporations Act*; no hospital may be incorporated without the approval of the Minister of Health. Each hospital has a board of directors responsible for its operations. The *Public Hospitals Act* and the regulations passed under it set out the framework for how hospitals function. The board of directors is required to pass by-laws providing for such things as the appointment of medical staff and hospital committees, and these by-laws must be approved by the Minister of Health. Hospitals obtain their operating funds from the Ministry of Health, making it virtually impossible for them to offer services or programs that the Ministry is not willing to finance. However, it would be difficult for the Ministry to impose a program on an unwilling hospital.

Most of the province's hospitals belong to the Ontario Hospital Association, which represents hospitals to governmment, and provides educational programs and a variety of other services.

Hospital Staff

Every hospital has authority to employ professional staff such as nurses, physiotherapists and dietitians. A hospital does not employ physicians (except for interns and residents in teaching hospitals); instead, it appoints them to the medical staff. A physician on the staff of a hospital has the privileges granted by the hospital board. These generally include the right to admit patients to the hospital and to diagnose and treat them there.

The *Public Hospitals Act* sets out detailed procedures for making medical staff appointments. Every application for a staff appointment must be referred by the administrator to the Medical Advisory Committee (MAC), which consists of representatives of the medical staff. The Credentials Committee, also composed of members of the medical staff, reviews the applicant's qualifications and reports its findings to the MAC. The MAC in turn makes a recommendation to the hospital board, which in most cases, the board adopts. A physician is entitled to receive reasons for the MAC's recommendation, and to have a hearing before the hospital board. A physician aggrieved by a decision of the board may appeal to the government-appointed Hospital Appeal Board. This tribunal, which is independent of any hospital, has the power to direct the hospital board to take specified action. A decision of the Appeal Board may be appealed to the Divisional Court, which may either direct the hospital board to take specified action, or may refer the matter back to the Appeal Board for a rehearing.

A hospital may choose to appoint a dental staff. No provision is made in the *Public Hospitals Act* for the appointment of members of any other profession.

Physicians control access to hospital services. Only they can admit a patient to hospital. Even when a patient is being admitted for a dental procedure, a physician must be involved in the admission. Once the patient is admitted, a physician's order is necessary for every test, medication and treatment. Every patient must be examined by a physician upon admission, and a physician is the only health care professional who may discharge a patient.

Health Insurance

The province administers a universal, comprehensive health insurance program, the Ontario Health Insurance Plan (OHIP), which covers hospitalization costs, the cost of most services rendered or ordered by physicians, and the costs of limited services rendered by other practitioners, such as chiropractors. OHIP covers all medically necessary services rendered by physicians. Physicians are generally paid per service rendered and there is no limit on the number of services that may be given per patient. Physicians may submit their bills to OHIP directly or to their patients who are then reimbursed by OHIP. Since June 20, 1986, physicians have been prohibited from charging fees for insured services in excess of the amounts paid for these services by OHIP. However, there is no limit on the overall amount physicians may charge OHIP in a year, and physicians may charge patients for uninsured services and administrative fees.

Hospitals may not charge patients fees for basic hospital services covered by OHIP, including standard ward accommodation, meals, tests, procedures, medications and supplies. They may charge patients for such extras as semi-private and private accommodation, telephones and televisions.

Practitioners of health disciplines whose services are not covered by OHIP, such as psychologists, have long sought inclusion in the plan. Other professionals, such as chiropractors, whose services are included but only to limited amounts, have sought to have the limits removed.

A noteworthy feature of the fee schedule in use under OHIP is that it does not distinguish between obstetrical services provided by general practitioners and those provided by specialists in obstetrics and gynaecology; both receive the same fee for the same service. Moreover, patients are free to choose either a general practitioner or an obstetrician for their primary care, because OHIP does not require patients to be referred to specialists by their general practitioners. OHIP does not, however, cover the cost of the services of a midwife.

Private insurance for services covered by OHIP is not permitted in Ontario.

Financing Health Care

Health care absorbs approximately 29 per cent of provincial government expenditures. In 1985-86 almost 86 per cent of the $9.2 billion health care budget was spent on hospital services, professional services, private laboratory services and drugs. Money for health care comes primarily from OHIP premiums and transfer payments from the Government of Canada (derived from general tax revenue). The Ministry of Health is under continual pressure to constrain growth in provincial health care spending.

Health Professions Education

Medical education is provided exclusively at universities, while nursing education is provided at both universities and colleges of applied arts and technology (CAATs).

Universities and CAATs depend on the provincial government for funding. Universities are corporate bodies independent of the government, and in principle, the government can neither force a university to mount a particular program nor prevent it from mounting one. However, without government approval, no public funds will be provided; conversely, funding can be used as an incentive for the establishment of new programs.

Who Provides Reproductive Care?
Physicians

A pregnant woman in Ontario is almost certain to be cared for during her pregnancy by a physician and to have her baby delivered by one. If the woman has a family doctor her first appointment is likely to be with him or her. In the past, that same family doctor would likely provide care throughout the pregnancy, deliver her baby, and care for them both after the birth. Today, it is just as likely that her family doctor does not deliver babies, in which case she will be referred during her pregnancy to another physician, more likely an obstetrician[5] than another general practitioner.[6] The Society of Obstetricians and Gynaecologists of Canada has developed a protocol dealing with the sharing of care between general practitioners and obstetricians.

Figures provided by the Ministry of Health based on OHIP billings show the declining involvement of general practitioners in obstetrics. In 1985-86, 70 per cent of Ontario's approximately 8,351 general practitioners conducted no deliveries at all. The percentage of all deliveries attended by general practitioners in 1985-86 was 31.5. Eleven years before, in 1974-75, general practitioners had attended about 50 per cent of the births in the province.

General practitioners continuing to conduct deliveries "specialize" in normal, uncomplicated cases. In these cases general practitioners still play a significant role. In 1985-86 they attended 43.9 per cent of vaginal (that is, normal, non-operative) deliveries.

The declining role of the general practitioner in obstetrics is mirrored by the expanding role of the obstetrician. It is estimated that Ontario has just under 600 obstetricians. In 1985-86, they attended 67.3 per cent of all deliveries, compared with 48.9 per cent in 1974-75. Obstetricians are specialists in high risk pregnancies and complicated deliveries, so it is not surprising that in 1985-86 they attended 90.5 per cent of multiple births and 91.2 per cent of caesarean sections. However, obstetricians also attended more than half (55.7 per cent) of the normal, vaginal deliveries.

Other physicians, primarily general surgeons,[7] performed 4.3 per cent of caesarean sections in 1985-86, but only 1.2 per cent of all physicians assisted births.

The distribution of deliveries among general practitioners, obstetricians and other physicians during 1985-86 is depicted in Table 1.

The declining role of the general practitioner and the expanding role of the obstetrician in ***normal*** obstetrics is not a phenomenon unique to Ontario; a similar shift has occurred in Quebec. In the United States, only about 42 per cent of the 67,000 general practitioners and family physicians practise obstetrics (Harsharm, 1983; AMA, 1987).

Physicians' organizations such as the Canadian Medical Association, the Ontario Medical Association, and, especially, the College of Family Physicians of Canada are concerned about general practitioners' declining role in obstetrics and would like to reverse, or at least to stem, the decline. They have said there are various reasons general practitioners choose not to practice obstetrics. General practitioners do not receive exhaustive training or clinical experience in obstetrics during medical school and internship. Many have no contact with general practitioners who do practise obstetrics. Therefore they lack role models and often begin practice with no secure sense of their competency in obstetrics (Klein, 1984). Their sense of insecurity may be compounded by the small number of deliveries available to them. While the birth rate has been declining in Ontario, the number of general practitioners practising in Ontario has been increasing.[8] The general practitioner may question if a few deliveries justify the efforts necessary to maintain competency, the increased liability insurance costs[9] and the anxiety about being sued for malpractice if the outcome is poor. As well, general practitioners are motivated by the desire to protect their lifestyle. Obstetrical practice is disruptive of family life and office appointment schedules. Finally, many physicians (obstetricians as well as general practitioners) feel that the OHIP fees paid for obstetrical services are inadequate compensation for the arduousness of obstetrical practice and its risks (CMA, 1987, College of Family Physicians of Canada: Ontario Chapter, 1987).

Geography influences whether a woman is cared for in childbirth by a general practitioner or obstetrician. Obstetricians are concentrated in the urban areas of southern Ontario. In large parts of northern Ontario, there are too few obstetricians to care for women with high risk pregnancies and deliveries, let alone the larger number of women with low risk pregnancies (Copeman, 1987; Klein, 1986). The lack of obstetricians in these locations also tends to increase the proportion of women having caesarean sections when vaginal delivery becomes difficult, because caesareans can be performed by surgeons.

A woman may receive care initially from a general practitioner but be referred to an obstetrician because complications develop in her pregnancy. The Ontario Antenatal Record, which is used by the majority of physicians, sets out guidelines for consultations with and referrals to obstetricians. The Record appears in Appendix 4.

Table 1: Deliveries Conducted by General Practitioners, Obstetricians and Other Physicians, 1985-86

Specialty	Vaginal Deliveries		Multiple Births		C-Sections		Operative		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
General Practice	38,754	43.9	108	8.8	1,155	4.4	781	4.7	40,798	31.5
Obstetrics	49,226	55.7	1,111	90.5	23,960	91.2	12,856	94.1	87,153	67.3
Other	309	0.3	8	0.6	1,151	4.3	13	0.09	1,481	1.2
TOTAL	**88,289**	**68.2**	**1,227**	**0.9**	**26,266**	**20.2**	**13,650**	**10.5**	**129,432**	**100.0**

Source: Ministry of Health, Information Resources and Services Branch

The physical care a woman receives during pregnancy is largely the same, whether she is seen by a general practitioner or an obstetrician. The first appointment includes a complete medical history and physical examination. Subsequent appointments take place monthly until the 28th week of pregnancy, bi-weekly until the 36th week, and then weekly until birth. The Society of Obstetricians and Gynaecologists of Canada has issued Guidelines for Prenatal Care, covering the frequency of visits, the routine physical examinations and tests to be conducted, special tests, diet and medication, plans for labour and birth, and postpartum care (SOGC, 1984, see Appendix 8). The OHIP fee schedule also sets out guidelines for the expected sequence of visits during pregnancy. The overall purpose of the visits is to detect complications or health risks as early in the pregnancy as possible so that appropriate action can be taken.

Most appointments during the pregnancy take place in the physician's private office, but some tests and procedures may require visits to a laboratory or hospital. A typical appointment with the physician lasts about five to 15 minutes after a sometimes lengthy wait. The woman will be weighed and have her blood pressure taken, either by the physician or by a nurse employed by the physician. Her urine will be tested. The physician will assess the wellbeing of the woman and her foetus, including checking the foetal heart rate and the size and position of the foetus, and looking for signs of complications in the pregnancy. The physician will ensure that any other procedures necessary to determine that the pregnancy is progressing normally are performed.

For the usual sequence of visits during pregnancy, the woman's physician will charge OHIP approximately $300.00. Each visit is charged separately. Special OHIP rules cover visits unrelated to the pregnancy, transfers of care from one physician to another, and other contingencies.

A woman is not necessarily cared for in labour and birth by the physician who cared for her during pregnancy. Indeed, she may also be cared for by different people during pregnancy if her physician works in a group practice. Some general practitioners have arrangements for shared care with other physicians, in which they provide most of the care during pregnancy and the other physicians conduct the births. As well, some physicians (no statistics are available on how many) have arrangements with colleagues for sharing on-call time. This helps physicians organize their time and preserve time for recreation, family life, and rest. It means, though, that a woman whose physician is not on call when she goes into labour will be cared for by another physician, whom she probably has not previously met.

For a normal vaginal delivery, a physician bills OHIP $225.30. Separate charges may be billed for additional procedures, such as induction of labour, breech birth, multiple births, caesarean section and operative delivery. OHIP pays the physician 30 per cent more if the birth occurs during the weekend or between 5:00 p.m. and midnight, and 50 per cent more if it occurs between midnight and 7:00 a.m. The charges for delivery include the care of the newborn immediately after birth.

After the birth, the physician ordinarily visits the woman every day while she is in hospital. Either a general practitioner or paediatrician examines the baby before it goes home with the mother. A final office visit takes place at about six weeks after the birth. At that visit the woman is physically examined and usually her family planning needs are discussed. The postpartum hospital visits will cost OHIP about $48, the office visit about $21.

Nurses

Approximately 130,000 people are registered with the College of Nurses of Ontario. About 100,000 are registered nurses and about 30,000 are registered nursing assistants.[10] These numbers include nurses in active practice, nurses who are temporarily not practising and those who are retired. About 73,700 registrants are working in nursing in Ontario. The vast majority of nurses are women.

Nurses have a variety of roles during the different stages of the reproductive cycle.

For many pregnant women, their first contact with a nurse will be in their physician's office. There a nurse may assist the physician and perform some procedures (for example, measuring blood pressure) but the nurse does *not* have an independent role in monitoring the health of the woman or her pregnancy.

Many women also have contact with public health nurses[11] during pregnancy. Public health nurses teach the childbirth education classes that all boards of health[12] in Ontario are required to provide. A smaller group of women, those identified as having high risk pregnancies (medical or social), receive individual visits from public health nurses to ensure they obtain adequate medical care and all necessary counselling.

Nurses actively care for women during labour and birth. In most hospitals these nurses are permanently assigned to the labour and delivery service although in some smaller hospitals, they are not; thus the nurses in smaller hospitals may not have developed the same level of expertise as nurses in larger hospitals. Labour and delivery room nurses are guided by hospital protocols and by standing orders issued by physicians. Nurses provide continuous care during labour and inform the physician of the woman's progress, and the physician makes intermittent visits as needed. Nurses try to provide labour coaching and emotional support to the woman and her partner but are rarely able to provide one-to-one care throughout a labour and birth, because they have more than one woman to care for at a time and because usually they must leave at the end of their shift. Some couples hire labour coaches to be present with them so that they can be assured of the presence of a person known to them throughout the entire labour and birth.

During the actual birth, nurses assist the responsible physician. If the baby arrives before the physician, the nurses may conduct the birth. Hospitals have often sought nurses with midwifery preparation to work in labour and delivery services because of their skill in recognizing abnormalities and because many have conducted numerous deliveries on their own.

Labour and delivery nurses care for the mother and baby during the first one to two hours after birth when intensive observation is very important. After this stabilization period, the mother and baby are transferred to the postpartum ward where another nursing staff takes over their care. In many hospitals, the mother and baby are each cared for by different nurses; however, in some hospitals, combined care is practised so that one nurse cares for mother and baby throughout a shift. In some hospitals, the baby stays in the mother's room much or all of the day, instead of in a nursery. This accommodation is called "rooming in."

The nurses monitor how the mother and baby are recovering from the birth. If the baby is not rooming in, they bring the baby to the mother for feeding. They teach new mothers how to bathe and dress their babies, and they may help them with breastfeeding.

The quality of the experience women have in hospital during childbirth depends heavily on the nursing care they receive. Women usually have many more interactions with nurses than with physicians. Nurses are present 24 hours a day and are expected to provide emotional support, reassurance and information.

Women usually leave hospital within three to five days after the birth, later if there has been a caesarean section. There are also early discharge programs, in which women go home within 48 hours of a normal birth.

At home, they again have contact with public health nurses, and some women engage private duty nurses at their own expense to help them while they recover from the birth. Boards of health are required by law to provide postpartum home visits, and they are notified of every birth within their area. Public health nurses visit all first-time mothers; visits to experienced mothers are made according to need. The visit must be made within three to four weeks after birth or discharge from hospital. The nurse generally checks to see if the mother and baby are in satisfactory physical condition and if the mother is caring for herself and the baby adequately. The mother has an opportunity to obtain information. The nurse's ability to provide emotional support to the woman is limited by the fact that in all likelihood she has never met her before, and that there are many other demands on her time.

Midwives

Although midwifery as a separate profession has not had legal recognition in Ontario for more than a century, midwives have continued to exist and midwives are practising in Ontario today.

There are individuals engaged in the private practice of midwifery outside the official system of health care. A small group of nurses is employed in the Chedoke-McMaster Nurse-Midwifery Project.

A third group of practitioners are nurses employed by Health and Welfare Canada to provide health care services to native Canadians in the far north. Although the Health and Welfare nurses do not officially function as midwives, they are primary providers of pregnancy and postpartum care, and are sometimes the only health professionals present at births.

Midwives in Private Practice Outside the Official Health Care System

The Task Force commissioned Norpark Computer Design Inc. (Norpark) to conduct a survey of midwives in Ontario. Information was also provided by the Association of Ontario Midwives and by midwives, apprentice midwives, childbirth educators, representatives of several chapters of the Midwifery Task Force, and past and present clients of midwives. As well, members of the Task Force spent a half day at the Midwives Collective of Toronto.

Number

Results from Norpark indicate that there are approximately 50 midwives currently practising in Ontario. The midwives actually surveyed by Norpark include midwives identified by the Association of Ontario Midwives (AOM), further midwives named by the midwives on the AOM list, and midwives who came forward in response to a notice placed in the AOM newsletter and an announcement on CBC Radio.

Norpark also identified and surveyed 59 individuals who regard themselves as midwives but are not practising. It has not been possible to estimate the total number of non-practising midwives.

Education

The Norpark survey obtained detailed information from 41 practising midwives. Of these, 11 are nurses registered with the College of Nurses of Ontario (CNO) and 30 are not nurses. There is a great diversity in their educational preparation. Of those who are registered nurses the majority have some combination of nursing and midwifery education, the latter having lasted one to two years. All obtained their education in England or Scotland. Eight of the 11 obtained a certificate or diploma at the end of the midwifery education program, and seven had some form of government or professional credential. Three of the 11 have not attended a formal midwifery education program. Of these, one is apprentice-trained, and two are self-taught. These three midwives indicated their training period had lasted one to two years.

Of the midwives who are not registered with the CNO, nine were educated at direct entry midwifery schools (schools for which nursing qualifications are not a prerequisite), 15 are apprentice-trained, and three are self-taught. The length of their training was generally two to three years; a few midwives reported a four-year training period. Fourteen have a certificate or diploma and seven have a government or professional credential.

The midwifery education of nine was at independent schools of midwifery. Three were trained in hospitals. Nine others were educated in various venues such as the Association of Ontario Midwives, apprenticeship, self-teaching, and birth counselling centres. Sixteen were trained in Canada, 14 of them in Ontario. Seven were trained in the United States.

Experience

The amount of work experience of the practising midwives varies greatly. The practising midwives who are CNO registrants have had between 30 and 2000 clients since completing their training. Half have had fewer than 100, while two have had more than 500. The number of births attended by this group since completing their training ranges from six to 2000, with the majority having attended fewer than 100. The midwives who are not registered with the College have had between zero and 350 clients since completing their training; most have had fewer than 100 clients while five have had more than 200. This group has attended between zero and 1100 births since completing their training, with just over half having attended fewer than 100.

Norpark observed that the wide variability in reported experience could be due to a number of factors including years in practice, location, the era in which the midwife practised, and difficulty recalling past workloads.

The births attended by the midwives took place in hospitals, clinics, birthing centres, homes and other locations, both in Canada and elsewhere. Hospital was the most frequent location of birth for all midwives. Of the practising midwives who are not registrants, seven have not attended home births, while 15 have attended between one and 100 home births; 11 have attended at least one hospital birth. Of the practising midwives who are not registrants, most have attended at hospital births, and all have attended at home births.

Somewhat surprisingly, 11 non-registrants said they delivered babies in hospitals; indeed, eight reported 10 or more hospital deliveries in a year. Norpark observed that these midwives may be reporting births they attended or assisted at, but for which they were not technically responsible. On the other hand, "it may mean that at least in some cases practising non-registered midwives do deliver in Ontario hospitals" (Appendix 3).

The practising midwives have cared for an average of about 35 clients a year and have attended at about 22 births a year. More than one-third of the registrants and one-quarter of the non-registrants have cared for fewer than 20 clients in a year. Two of the registrants and four of the non-registrants have attended at fewer than 10 births in a year.

Types of Practice

Three-quarters of the practising midwives who are not College registrants are in group practices. Four practice independently by themselves. Two said they practise independently with family practitioners, and one said she practises independently with an obstetrician.

Of the College registrants, four are in group practices, four are in independent practices with family practitioners, one practises independently with an obstetrician, and one is an employee in a physician's office. None practises by herself.

Content of Practice

The practising midwives provide a variety of servies, including pregnancy care, prenatal classes, labour care without delivery, labour care with delivery, care for the new mother, care for the newborn, family planning, and health counselling and education. According to the Norpark survey, no single function stands out as taking up the majority of the midwives' time.

Arrangements with Physicians for Home Birth

The practising midwives who attend home births have a variety of arrangements with physicians. Three midwives who are CNO registrants and six who are not registrants said they have a cooperative arrangement with a physician who provides hospital liaison and emergency care. One non-registrant said she had an "uncooperative" relationship with a physician. Two registrants and two non-registrants said they have no arrangement with a physician. Seven non-registrants said they have a variety of other arrangements.

Biographical Information

All the midwives surveyed are women. The average age of the practising midwives who are College registrants is 44.4 years, and the average age of practising midwives who are not registrants is 33.8 years. Very few of the practising midwives are over 50, and very few of the non-registrants are over 40.

Most of the practising midwives are married. More than half of all practising midwives are the primary caretakers of children.

The practising midwives live in all regions of Ontario. However, the majority of midwives who are not College registrants live in central and southern Ontario.

Intention to be Trained and Practise

The majority of the currently practising midwives expressed an intention to practise midwifery when it is legalized in Ontario. They said their actual decision to practise would be influenced by the duration, costs, and prerequisites of any required training course, as well as its geographical location. Many other factors were also mentioned as potentially influencing the decision to retrain and practise, including autonomy, freedom to practise in a variety of settings, the cost of insurance, provision for medical and hospital backup, the degree of independence of the governing body, whether practice would follow the "midwifery model" versus "physician control", continuity of practice while the midwife was qualifying, and scope of practice. All the practising midwives were willing to take a qualifying course of eight months duration or less; their willingness to take a course of 16 months duration was less certain.

Comments

The Norpark survey revealed great diversity in the educational preparation and practice experience of the midwives currently practising in Ontario. Along with a lack of official recognition of midwifery comes an absence of regulation of who may call herself a midwife and who may perform the functions of a midwife. A midwife practising in Ontario today may be a graduate of a formal midwifery school or she may be entirely self-taught. She may have cared for hundreds of clients or very few. She may have attended a handful of births or hundreds. She may have a cooperative arrangement with a physician for home birth backup, or she may have no arrangement at all. It is entirely up to the client to ascertain the midwife's qualifications, experience, and arrangements for physician backup, and to judge whether they are adequate.

Professional Association

The midwives have an active professional association, the Association of Ontario Midwives (AOM). In addition to engaging in activities typical of a professional association, such as lobbying on behalf of the profession, the AOM engages in activities more typical of a governing body. For example, it has drawn up standards and qualifications for midwifery practice. Adherence to these is mandatory for membership in the AOM. They appear in Appendix 7.

The AOM has a Code of Ethics that deals with professional incompetence and misconduct in the practice of midwifery. Professional misconduct is exhaustively defined, and includes failure to maintain the standards of practice of the profession; making a misrepresentation respecting a remedy, treatment or device; charging an excessive fee; failing to maintain required records; disclosing confidential information about a client; and conduct relevant to the performance of midwifery services that would reasonably be regarded by midwives as disgraceful, dishonourable, or unprofessional.

The AOM Constitution provides that a member may be disciplined when the Complaint and Discipline Committee decides, on the basis of a complaint from a client and after giving the midwife an opportunity to be heard, that she has been guilty of professional misconduct or other conduct unbecoming to a member, or that she has breached the AOM Constitution. Discipline may consist of temporary or permanent suspension of membership, a fine, or reprimand. The AOM cannot, of course, prevent anyone who is not a member of the Association from practising as a midwife.

The AOM has issued a Risk Screening and Consultation Protocol for use in determining when a midwife must consult with another midwife for a second opinion, when she must consult with a family physician or obstetrician and when she must consult with another appropriate specialist. The Protocol states that it is assumed there will be cooperation between members of the health care team, and acknowledges that its use may be limited in areas where "cooperative relationships have not yet developed." It is the midwife's obligation to make every effort to follow the protocol. It covers risk factors that appear or develop in the woman during the initial history and physical examination, during pregnancy, labour and birth, after birth, and during the postpartum period. It also covers risk factors in the baby. It includes contraindications to home birth.

The AOM has an apprenticeship protocol that prescribes the content of apprenticeships including clinical skills, academic subjects, and numbers of clinical experiences.

Legal Status

Midwives who practise privately outside the official health care system have no legal recognition. A midwife could be charged with contravening the *Health Disciplines Act* by practising medicine (which by definition includes obstetrics) without a licence. It could be argued in her defence that the practice of midwifery is not the same as the practice of obstetrics and that she, therefore, does not require a licence.

As far as we are aware, no midwife has been prosecuted in Ontario for practising medicine without a licence since the early part of this century, and whether midwifery is included in the practice of medicine has been made moot with the government's decision to recognize and regulate midwifery.

Midwives Collective of Toronto

We were grateful to have the opportunity to visit a midwifery practice in Ontario. Two members of the Task Force and its Executive Director visited the Midwives Collective of Toronto, a group practice of five midwives. At the time of our visit, they included apprentice and self-trained midwives (one of whom is a registered nurse) and graduates of direct entry midwifery schools in the U.K. The Collective midwives are active in the affairs of the AOM. Their practice is located in a house in central Toronto.

The midwives provide a package of pregnancy, labour, birth, and postpartum care. Detailed protocols guide the care given by each midwife. Every prospective client is given a package of written materials that documents the informed choice agreement between the midwife and client. They describe such matters as services to be provided, the status of midwifery in Ontario, the parents' role and responsibilities, the risks of home birth, the education and experience of each midwife, and the Collective's fees. Every woman is assigned a primary midwife who provides most of her pregnancy care and who agrees to be present at the birth. She is also assigned a backup midwife who provides some of her pregnancy care and is the second midwife present if she gives birth at home.

The woman visits her midwife at least once a month until the 28th week, every second week from the 29th to the 36th week, and once a week thereafter. Each visit lasts about one hour. The woman must also be seen by a physician at the same intervals throughout the pregnancy. This is explained as "double protecton for the home birth client if she has two opinions of her condition that substantiate one another." It is also a way of ensuring that the mother has necessary laboratory tests performed since the midwives do not have access to a laboratory. The midwives have no formal arrangements with any physicians, but there are general practitioners, obstetricians, and paediatricians with whom they have good working relationships and to whom they refer their clients. The Collective also offers childbirth preparation classes to its clients, as well as to other couples. From time to time it sponsors information evenings.

If a woman chooses to give birth at home, she will be attended by her primary midwife, the backup midwife, and possibly an apprentice. The Collective's protocols require the primary midwife to have attended 50 home births; she and the backup midwife together must have attended at least 100 home births. The primary midwife is responsible for monitoring the labour and the birth; the backup midwife usually arrives late in labour to be present for the birth. One midwife, therefore, is available to care for the woman during the third stage of labour (that is, immediately after the birth), while the other cares for the baby. Prior to the birth, the primary midwife will have visited the mother in her home to ensure that it is suitable for a birth and that the necessary supplies have been obtained. A woman who must be moved to hospital during labour will be transported in a private vehicle or an ambulance, depending on the urgency of the situation.

If the woman chooses to give birth in a hospital (or is not suitable for home birth), the primary midwife will attend her at home until she is in active, well-established, labour or as long as is appropriate. She will then accompany the woman to hospital and stay with her for the duration of the labour and birth if the hospital permits this. The midwife provides coaching and emotional support, and acts as the woman's advocate in dealing with hospital staff. Hands-on care will be provided by nurses and the woman's physician.

The majority of the Collective's clients choose hospital birth. Many of the clients are first-time mothers 35 to 42 years old who are having carefully planned or long awaited babies.

After a home birth, the midwife stays with the mother and child for at least two hours, until both are stable and secure. She will visit the mother and baby at home every day for the first three days or on the first, second and fourth days postpartum and will make two more home visits during the next 10 days. The midwives require that the baby be seen by a physician within 48 hours of birth. If the woman has given birth in hospital, the midwife will visit her at home after she is discharged. Care usually ends with a check-up about six weeks after birth.

Members of the Collective believe that planned home birth is a safe option for healthy mothers and that there are distinct risks and benefits to any place of birth. In their view, it is the parents' responsibility to inform themselves, to weigh the risks and benefits, and to decide for themselves where to give birth. Parents are advised that:

> Adequate prenatal care is the most important factor in protecting and avoiding possible complications. Even though most complications can be screened prenatally, difficulties can arise during labour and birth. Most of these are not life threatening and can be dealt with at home or safely transported to hospital. There are some rare circumstances when use of the technology available only in hospital may be essential for the safety of mother and/or baby. Choosing to give birth either at home or in hospital means the acceptance of certain risks which may be life threatening. A good backup arrangement with the doctor and hospital is essential for safe home birth. We can provide you with information about some of the complications which may arise. We encourage you to discuss with us our experience in dealing with them.

The Collective's protocol states that it cannot support any midwife who chooses to attend a high risk birth at home. If a midwife were to propose to attend a high risk birth at home, members of the Collective would meet to review the case. In fact, this rarely occurs.

At the time of our visit, the midwives in the Collective were charging $550 for pregnancy care and a hospital birth and $675 for pregnancy care and a home birth. These charges cannot be recovered by the client from OHIP.

The physical, pregnancy and postpartum care provided by the midwives in the Collective is similar to that usually provided by physicians to healthy women with uncomplicated pregnancies. The woman visits both the midwife and the physician at the same intervals, and the same physical signs are checked and monitored. Only physicians, of course, currently have access to laboratory and hospital-based services, and only they can manage hospital births. The care given by the midwives during home births exhibits the midwifery philosophy of non-intervention. The woman decides who is present at the birth. The midwives encourage the woman to move about during labour and to adopt whatever birthing position is comfortable. Every effort is made to avoid the use of anaesthesia, and episiotomies are rare.

A striking difference between the pregnancy care provided by the Collective midwives and that provided by physicians is the attention the midwives give to the psychological and social needs of their clients. Because actual physical care takes up a small part of the hour-long appointments, much time is devoted to discussion with the woman, counselling her on such matters as exercise and diet, giving information about her pregnancy, and providing emotional support.

All the midwives in the Collective are women and all are under 40 years old. The fact that the midwives are of the same sex and approximate age as their clients is conducive to the congenial relationships that develop between them. The comfortable informality of the house in which the midwives work and the midwives' willingness to make home visits also aids in this. The relationship between midwife and client is strikingly egalitarian and non-authoritarian, as evidenced by such important features as the midwives' philosophy that parents are responsible for making decisions about care, and by such small things as the use of given names and the absence of hospital gowns and white coats.

Not all Ontario midwives practise in the same way as the Collective midwives. Protocols of practice vary. It is our impression that styles of practice vary greatly. Some midwives cater to young, urban, professional women. Others cater to women for whom a midwife is consistent with an "alternative" lifestyle.

The attractiveness of midwifery care to many different women is best expressed by the women themselves. The following quotations are extracts from submissions to the Task Force:

> The keynote for me is "nurturing". Going to a good midwife was an affirmation of womanhood. Usually they have given birth themselves and have a deep respect and appreciation for the beauty of birth, motherhood and women in general. They shared with me the joy and thrill of feeling life growing within, helped me feel less alone with my anxieties and fears and took the time to listen. They understood that it was their privilege to attend my baby's birth and helped me feel the specialness of this time in my life.

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> I saw my midwife about as often as I saw my doctor with my first pregnancy, and somewhat more frequently this time. However, the visits are completely unhurried, an

hour being a typical appointment length. We are able at length to discuss the physical changes and psychological adjustments I am experiencing. The midwife works with me to help me understand what I am going through. She does not merely seek to reassure me that what I am experiencing is normal. She is genuinely interested, as well as knowledgeable. She does not patronize me.

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At the hospital, she fulfilled the role of the objective presence every time a decision had to be made about some further step. Ironically the birth of my son was only accomplished with considerable intervention. However, the presence and participation of the midwife made me feel that I had participated in the decisions that had been made. I did not feel, nor did my husband, that someone else had imposed the use of medical technology upon me.

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My expectations were fulfilled completely at the time of delivery. I felt at ease during my labour, because I had someone with me whom I knew and trusted. I was able to rely upon her to tell me how my labour was progressing, and most importantly, when it was time for the hospital. These services allowed me to concentrate solely on the labour; they removed the anxiety of "what should I be doing now?"

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I chose midwifery because I felt strongly that the traditional approach to maternity care would not respect my needs as an individual during pregnancy, labour and the postpartum time. I wanted someone who would counsel myself and my husband throughout my pregnancy and to whom I could confidently give myself during labour. I was partly motivated by visions of being "just another labouring woman" in a hospital corridor, being deprived of privacy and surrounded by strangers. In my experience doctors simply do not have the time to give to an individual patient. I knew a midwife would be committed to staying with me throughout my labour and delivery. But, perhaps as important, personal consultations and prenatal classes in the preceding months would establish a foundation of trust and friendship. Because I was able to approach my midwife freely with questions and concerns I felt no fear, even at the peak of labour. I trusted my midwife to inform me of any changes which might necessitate a move to hospital.

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My midwife came to my home after my membranes ruptured in order to monitor the foetal heart rate, check my dilation and provide support, comfort measures and suggestions for possible coping mechanisms. She had a calming and steadying influence on both my husband and myself. Having her there helped us both to relax and allowed my body to do its work, knowing that my child was coping well with the stress of labour and that I was making progress.

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Having worked in the labour and delivery unit where I planned to give birth, I knew that my experience would be greatly dependent upon which staff nurse was assigned to care for me, how busy she was and her attitudes toward and supportiveness of natural birth. I felt having someone with me providing one-to-one coaching, care and support would be an important factor in my ability to have a natural birth. The staff nurses in Labour and Delivery are often too busy or not inclined to invest the time such support requires.

Despite being an obstetrics nurse, I, like any pregnant woman, had questions and concerns which books did not address. The allotted five minutes with my obstetrician did not allow for, nor encourage, extensive discussions or question-asking. On the contrary, prenatal visits with my midwife lasted for up to an hour, allowing for physical assessment and a relaxed atmosphere for questions and discussion.

Nurses in the Chedoke-McMaster Nurse-Midwifery Project

Objectives and General Description

A pilot project in midwifery care was begun in 1983 by members of the nursing and obstetrical staffs of the McMaster Division, Chedoke-McMaster Hospitals and the Faculty of Health Sciences of McMaster University in Hamilton. The objective of the project is to develop and evaluate a model of midwifery care within a teaching hospital. The philosophy is to promote the normal process of pregnancy and birth, the involvement of family and friends, and the teaching and counselling functions of the midwifery role. The project was initiated without special funding; existing personnel and their schedules, budgets, administrative relationships, and medical-legal frameworks have been used in the organization and operation of the project.

The project has three components: the clinical services provided to women and their families, a research program, and an in-service education program. Women who experience an uncomplicated pregnancy and birth can receive pregnancy, childbirth and postpartum care. They may refer themselves or be referred by a physician. Screening criteria are applied at the first visit, and are reviewed during pregnancy and again at admission in labour. Consultation with, or transfer of care to, an obstetrician is arranged when indicated.

Nurses with expertise and interest who were already employed in the Department of Nursing Services at the project's inception were selected as participants. Criteria for selection included excellent clinical and interpersonal skills, commitment to the principles of midwifery care, and willingness to undertake added education. Five of the 10 nurses have a midwifery credential from another jurisdiction and the remainder have varying amounts of experience in maternity care. For none of the participants is the project the only job responsibility. Thus, while the nurses function in the more autonomous midwife role part of the time, at other times they continue to function as staff nurses in the labour and delivery unit of the hospital.

A committee of the College of Physicians and Surgeons of Ontario, College of Nurses of Ontario, Ontario Hospital Association and Ontario Medical Association authorized the delegation to designated nurses in the project of specific tasks essential to the midwifery role.These include delivering the infant, performing and suturing an episiotomy, repairing a laceration, administering a local anaesthetic for that repair, assessing the infant immediately after birth, and administering medication to control uterine bleeding. These activities were initially taught and performed under the supervision of the medical staff. This is consistent with the way that other delegated medical acts are managed in hospital settings.

Clinical Service Activities

The clinical service was initiated early in 1984 and was implemented in stages. The first stage was a pilot research study confined to labour and birth care. A formally designed randomized allocation of women to nurse only care or conventional (nurse and physician) care was conducted. This step was taken deliberately in order to address the feasibility of nurses as primary birth attendants. At the conclusion of the feasibility study in 1985, the clinical activities were expanded to provide pregnancy care to a defined group of women who sought or were referred for care.

At the time of our observation in the spring of 1987, the clinical service operated as follows. Prenatal visits were provided in the outpatient area of the obstetrics department. Two members of the project staff provided most of the pregnancy care, while other members were assigned to clinic days as their schedules permitted. Approximately 10 new patients were accepted per month for total care; and two to three more received shared care, consisting of alternate visits with their referring general practitioner throughout pregnancy. This option was developed for general practitioners in the community who provide pregnancy care to women in their practice, but do not follow them for labour and delivery care. The number of women accepted was limited by the available staff resources; more referrals were received than could be accommodated. The consultant obstetrician met each new woman accepted for care, reviewed her medical record, and was available at each visit if problems arose.

The nurses/midwives were assigned on a scheduled basis to the labour and delivery area and assumed responsibility for the care of women from the midwifery clinic when they were admitted in labour. Consultation was available from the on-call obstetrician who was present in the hospital at all times. Women were asked to complete a birth plan which described their preferences for such things as birthing positions, and methods of pain relief and their concerns about the birth process. The midwives provided physical care, emotional support, and explanations as needed. They also assessed the progress of labour. Normal, vaginal deliveries were conducted in the labour rooms. The parents decided who could attend the birth. Women might choose either to go home within several hours of birth or to stay in hospital for about three days. Those who left within 48 hours of delivery were eligible for referral to a community-based early discharge program that provides for public health nurse visits to the home to assess mother and infant. While the woman was in hospital, she received daily visits from one of the nurses/midwives. Medical care of mother and infant was the responsibility of the obstetrician and paediatrician or general practitioner. The woman might return to the midwives in the outpatient clinic in six weeks for a postpartum visit or she might see her physician.

Research Activities

The research component of the project has included the initial randomized allocation to labour and birth care mentioned earlier. The feasibility issues studied in that early phase were:

1. the willingness of women to have a nurse as the primary birth attendant in the hospital setting,
2. the availability of the nurse/midwives to provide the care under the existing staffing arrangments and scheduling system,
3. the design of measures of client satisfaction, and
4. the suitability of data collection methods for measuring obstetrical outcomes.

These activities were useful in preparing an application for funds to conduct a large evaluation study of clinical and cost outcomes. The application was recommended for funding for July 1986 but was deferred because of the deliberations about the structure of the midwifery profession. Descriptive data about the group of women cared for during 1986-87 were being accumulated for review. As well, a client/consumer advisory group was established to provide input and make suggestions for changes so that the service can be responsive to consumer needs.

Educational Activities

The nurses/midwives who participate in the project are required to attend an in-service educational program which focusses on selected study topics, case discussions, midwifery practice issues, and development of the midwife's role. The in-service educational program is designed to meet group and individual learning needs and uses faculty members from the nursing and obstetrical departments. Because of the requirement for increased knowledge and independence, those staff members who do not have a baccalaureate degree in nursing are required to enroll in university courses pursuant to that degree.

All participants in the Project acknowledge the difficulty in moving from a nursing role with restricted decision-making to the more autonomous and responsible midwifery role.

Comment

The project is one model of hospital based care. It represents a first attempt to implement a sanctioned midwifery role in the existing practice environment. It was relatively inexpensive to mount and caused little disruption. The new role has led to increased job satisfaction and increased education for the nurses/midwives, and it has offered women an option for care that had not previously existed. The disadvantages include the scheduled staffing system, which provides little continuity between the pregnancy and labour and birth caregivers. No individual woman knows for certain who will be with her in labour. The written birth plans, shared approaches, and good communication among the staff help to offset this problem, but it is a distinct disadvantage for some clients. Because the service is institutionally based, home visits during the pregnancy and the postpartum period are not provided. A further problem is the blurring of roles that occurs because the staff members contribute only a portion of their time to the midwifery project and otherwise are employed as staff nurses in a busy tertiary care setting.

The project's success is due, in large part, to the substantial personal commitment of the nurse-midwives. Over the long-term no project can depend so heavily for its success on the motivation and sacrifices of its employees.

Health and Welfare Nurses

The Medical Services Branch of Health and Welfare Canada employs nurses to provide primary health care to native Canadians living in the far northern reaches of Ontario.[15] In the region's two administrative zones there are 35 isolated communities, none with a resident physician. Health care is provided at 11 nursing stations which in 1986 were staffed by 32 nurses. Zone headquarters at Moose Factory and Sioux Lookout provide medical backup and hospital services.

The nurses provide comprehensive pregnancy care, childbirth education and postpartum care to a total of about 550 women each year. An effort is made to have every pregnant woman visited several times in her community by a physician. Women who require specialist care are generally transported to Moose Factory or Sioux Lookout or to medical centres in Thunder Bay or Winnipeg unless a local visit can be arranged.

The Branch's policy in the two zones is to transport pregnant women to hospital for childbirth. Ideally they are sent to Moose Factory or Sioux Lookout about two weeks prior to the expected date of birth, where they are provided with room and board until they go into labour. They are then admitted to hospital where physicians are responsible for managing the births.

Despite this policy, a few births do occur in the isolated communities. Some women refuse to leave their families, due dates are sometimes mistaken (or misstated, in order to postpone or prevent transport), and labour sometimes begins prematurely. Once labour begins, it is rarely possible to transport the women to hospital, because of great distances, adverse weather conditions, and inaccessibility of such locations as trap lines and hunting camps. The nurses provide labour and delivery care to women who refuse to be transported or who do not make it to hospital.

During 1984, the last year for which statistics were provided to us, 400 women in the Sioux Lookout zone gave birth, and 12 of them did so at nursing stations. In the Moose Factory zone three of the 150 women who gave birth did so at nursing stations.

The midwifery preparation of the nurses varies. In 1986, four of the 32 were fully trained midwives, six had taken a course in Outpost Nursing offered by Dalhousie University and two had taken a Primary Care course provided by the Medical Services Branch. Both the Outpost Nursing and Primary Care courses include obstetrics, but they are not equivalent to midwifery education. At one time all the nurses were recruited from the U.K. and other countries because of their midwifery preparation and because of the dearth of midwifery education in Canada. The Branch still prefers to hire nurses with midwifery qualifications to work in nursing stations, but is unable to recruit enough of them. We were told by the Regional Nursing Officer for Ontario that midwives "are invaluable for the quality and depth of the prenatal care they provide throughout pregnancy, for coping with occasional confinements, and for post-natal care" (Lovell, 1986).

Dr. Elizabeth Roberts, a physician with experience in caring for native women in northern Ontario, told us that one of the particular ways midwifery preparation could benefit the nurses and their clients is by increasing the accuracy of predicting due dates; more accurate predictions would result in shorter stays in Sioux Lookout and Moose Factory, as well as fewer unexpected births in nursing stations. She said that detection of complications in pregnancy could also be improved (Roberts, 1986). Others suggest that employing midwives in northern communities would enable the women to give birth there, instead of being transported to distant hospitals.

The transportation of women out of their communities to give birth in hospital has been criticized as causing undue hardship to native women and their families, without sufficient evaluation of its benefits. Responsibility for administering health care is being transferred from Health and Welfare Canada to native organizations in accordance with federal government policy. As this occurs reproductive care policies and practices are likely to be reviewed. It is possible that the availability of Canadian-trained midwives will affect the decisions made about where native women living in isolated communities should give birth and who should attend them.

Childbirth Educators

The fact that boards of health are required by law to provide childbirth education classes is an indication of the importance assigned to educating pregnant women. Private organizations such as the Childbirth Education Association also provide childbirth education classes in many parts of Ontario. These organizations often have a particular philosophy or approach to childbirth. The hospital classes are sometimes accused of teaching women to be "good patients", while the community classes are sometimes accused of providing incorrect or insufficient information.

Labour Coaches

Some women engage labour coaches to assist them in labour. These coaches can help them to breathe appropriately and relax, using specific techniques of prepared childbirth, and can provide emotional support and encouragement. Becoming a labour coach is sometimes a first step toward becoming a midwife.

Places Where Care is Provided

Medical Care

The majority of physicians in Ontario work in private practices. Their offices are located in medical centres, hospitals, shopping malls, office buildings, and premises in and adjacent to their own homes.

A small number of physicians work in Health Service Organizations (HSOs) and Community Health Centres (CHCs). Both HSOs and CHCs are funded by the Community Health Programs Branch of the Ministry of Health rather than by OHIP. HSOs can be established by physicians, community organizations, or hospitals. They are paid an amount for each enrolled patient. Both the amount and method of payment are known as capitation. The capitation per patient reflects the average value of OHIP services expended on people of the same age and sex. HSOs also receive bonus payments if their patients use acute care hospital services at a lower than average rate. Patients enrolled in HSOs pay ordinary OHIP premiums; they are free to obtain health care wherever they wish. If a patient does obtain health care elsewhere, and the care was available at the HSO, the HSO suffers a financial penalty. Capitation is generally regarded as cost-effective. It encourages health promotion, illness prevention and teamwork among physicians, nurses and other practitioners. Although the majority of physicians working in HSOs are general practitioners, some specialists also work in them.

CHCs are usually established in communities with particular health needs. Because these needs often arise from social and economic conditions, CHCs frequently offer social services as well as primary health care. CHCs must be sponsored by community organizations. Like HSOs, they offer teamwork among physicians, nurses and other practitioners; unlike HSOs they do not currently provide any medical specialty services. CHCs receive their funding from the Ministry according to annual, program-based budgets; their patients pay regular OHIP premiums and are free at any time to obtain care wherever they wish.

The Ministry of Health encourages the establishment of HSOs and CHCs. It regards them as effective alternatives to conventional private practice, partly because their funding mechanisms are more economical than fee-for-service, and partly because of their emphasis on interdisciplinary teamwork and health promotion.

At present, most obstetrical care is provided by physicians in conventional private practices. Women are free to obtain care from the physician of their choice — general practitioner or obstetrician — and they may make a new choice at any time.

Hospital Care

Nearly all women in Ontario give birth in hospital. Ontario has 165 hospitals with maternity beds. The number of maternity beds per hospital ranges from two to 82 (OHA, 1987).

Since the late 1970s, Ontario has been engaged in a process of rationalizing obstetrical services through regionalization.[11] The theory of regionalization is that scarce resources can be used most effectively, and the best care provided, if there is a good match between the level of risk posed by the pregnancy or birth and the facilities available in the hospital. Both women and hospitals are classified as falling into three groups or levels. The 85 per cent of women whose pregnancies are of no predictable risk may give birth in any obstetrical unit. The 12 per cent of women whose pregnancies present moderate risks should give birth in Level II units. The three per cent of women with high risk pregnancies should give birth in Level III units. Of course, the ideal match of women to hospitals will never be perfectly achieved. Only one-half to one-third of the

15 per cent of pregnancies that carry moderate to high risks can be identified before labour.

Implementation of the policy of regionalization is far from complete in Ontario. The province has been divided into six planning regions. At first, each had a perinatal care committee; these were later disbanded, but their reinstatement has been recommended by the Provincial Advisory Committee. Level III hospitals have been identified. However, some northern Ontario Level III hospitals lack the necessary expert medical and nursing personnel. The identification of Level II hospitals is in progress. Some obstetrical units in northern Ontario, whose numbers of births and capability to handle obstetrical emergencies would probably warrant their closure if they were located elsewhere, will probably continue to operate in order to meet local needs.

Hospitals are accredited by the Canadian Council on Hospital Accreditation (CCHA). Neither the CCHA nor the provincial government monitors or regulates specific hospital practices in the provision of obstetrical and newborn care. The federal government has published standards of care but does not monitor compliance with them. The Society of Obstetricians and Gynaecologists of Canada has issued guidelines for pregnancy care, including a guideline specifically dealing with electronic fetal monitoring; these are reproduced in Appendix 8. The Canadian Institute of Child Health, a non-profit organization based in Ottawa, surveyed obstetrical practices in hospitals across Canada in 1980 and 1985. The Institute made its 1985 survey results for approximately 150 Ontario hospitals available to the Task Force.

The survey showed that there is considerable variation in hospital facilities and practices. For example, 51 per cent of the hospitals that responded to the survey have only single-bed (private) labour rooms. Eleven per cent permit vaginal births to take place in combined labour and delivery rooms. Thirty-three per cent of the hospitals said "hardly any" women are shaved,[15] while 33 per cent stated almost all are shaved. In 40 per cent of the hospitals, very few women receive intravenous fluids, while in 16 per cent, almost all women receive them. In 18 per cent of hospitals very few women receive enemas or suppositories,[16] while in 28 per cent, almost all do. Epidural anaesthesia is available in 72 per cent of hospitals; in 23 per cent, more than half of women receive an epidural and in 24 per cent, fewer than 10 per cent of women do. Variations similarly exist in policies and practices regarding who may accompany the mother during labour and birth, the number of days the mother and baby stay in hospital, rooming in, breastfeeding, staffing patterns, and dress requirements for staff. Perhaps more surprisingly, the survey also showed variation in administration of routine tests and medications to newborns. For example, 50 per cent of hospitals administer Vitamin K (to prevent newborn haemorrhage); four per cent of hospitals said they do not give an Apgar score (the standard method of scoring the physical condition of the newborn at one and five minutes after birth).

The Perinatal Outreach Program of Southwestern Ontario, based at St. Joseph's Hospital in London, tries to set standards for the hospitals in its catchment area. Its bulletins have notified hospitals of correct practice in many areas of childbirth care. In the fall of 1985 a consensus conference on vaginal birth after caesarean section (VBAC) was held in Niagara-on-the-Lake. Its recommendations regarding the appropriateness of vaginal birth after previous caesarean section were adopted as Guidelines of the Society of Obstetricians and Gynaecologists of Canada. Whether they will be widely implemented across the province remains to be seen.

Although the variations in hospital practices might suggest that there is no single "right way" of doing things, in fact some practices are preferable to others. The effectiveness of some traditional practices, such as routine shaving, has been challenged or discredited.Supplementary bottle feeding can interfere with the mother's efforts to establish breastfeeding. Other practices, such as rooming in, encourage bonding between mother and baby. Permitting fathers and siblings to accompany the mother in labour, and to visit her and the baby freely after the birth, help the family as a whole to accept and adjust to the new member. In the case of women from different cultures, efforts must be made to appreciate and accomodate their birth traditions, and feelings of isolation that may be exacerbated by language difficulties. Very young or single mothers, and those with previous unhappy birth experiences can best be accomodated in a system that responds positively to client needs. Flexible, humane hospital practices go a long way toward satisfying the woman's desires for a satisfying birth experience, while rigid, insensitive practices are a major source of dissatisfaction with hospital obstetrical care.

The System's Achievements: Outcomes and Satisfaction

Obstetrical Outcomes

Both perinatal and maternal mortality rates have improved dramatically in Canada over the past 35 years. According to Statistics Canada, the perinatal mortality rate (the number of births after the 28th week of pregnancy plus deaths during the first six days of life per 1000 total births) declined from 37.9 deaths per 1000 births in 1950 to 8.7 deaths per 1000 in 1985. The maternal mortality rate (deaths due to delivery and complications of pregnancy, childbirth and the puerperium) declined from 11.4 deaths per 10,000 births in 1950 to 0.4 deaths per 10,000 births in 1985. Ontario's perinatal mortality rate for 1985 was 8.7 per 1,000 births, and the maternal mortality rate was 0.7 per 10,000 births. (Source: Births and Deaths—Vital Statistics, Vol. 1, 1979-85; Vol. 3, 1977, Vital Statistics and Health Statistics Section, Health Division, Statistics Canada; quoted in CMA, 1987).

The Federal Task Force on High Risk Pregnancies and Prenatal Record Systems partly attributed the reduction in mortality rates to the impact of regionalization of reproductive care services, the identification of risk in pregnant women, and the provision of specialized care for high risk women and their babies (Department of National Health and Welfare, 1982).

Ontario's perinatal mortality rate compares favourably to rates in other countries, although lower rates do exist. The rates for England and The Netherlands in 1984 were 10.8 and 10.3 respectively, while the rates for Denmark, West Germany and Sweden were 8.4, 8.59 and 7.32 respectively. Iceland's rate was only 6.05.

The low overall perinatal mortality rate for Ontario of 8.7 in 1985 was not achieved in all parts of Ontario (Advisory Committee on Reproductive Care, 1987). Some northern regions have much higher rates, and there are variations among districts within a single municipality, such as Metropolitan Toronto (City of Toronto, 1974).

In evaluating reproductive care, the frequency of caesarean section and operative delivery (delivery using forceps or vacuum extraction) is considered a meaningful indicator. International comparisons are especially revealing since women and childbirth are physiologically similar everywhere. Thus variations in the frequency of these procedures relate primarily to caregivers and clinical policies, not to clients (World Health Organization, 1986; Anderson and Lomas, 1985).

In Ontario in 1985-86 only 68.2 per cent of births were normal vaginal deliveries. One in five births (20.2 per cent) was a caesarean section and one in 10 (10.5 per cent) was an operative delivery (OHIP). These rates are much higher than caesarean section and operative delivery rates in many European countries (World Health Organization, 1986).

Satisfaction With the System

The level of satisfaction of women with the current system of reproductive care is very difficult to gauge. The Task Force received letters and heard submissions from many women, and a fair number of men, who expressed dissatisfaction with the care they and their families had received. They spoke of indifference and insensitivity, inadequate or contradictory information, and unnecessary assaults on their dignity. Those working with immigrant women, women from troubled socioeconomic backgrounds, and those seeking VBACs (vaginal birth after caesarean) had particularly pointed concerns about the existing system.

In March 1987, the Canadian Medical Association released Obstetrics '87, a study of obstetrical care in Canada, in which it reported on a national survey of the satisfaction of Canadian women with obstetrical care. The survey was conducted for the CMA by the Health Services Research Unit of the Department of Community Health and Epidemiology at Queen's University in Kingston, together with Goldfarb Consultants, a private polling firm. Telephone interviews were conducted with 2013 women aged 20 to 34 who had had a live birth within the previous two years.

On the basis of the survey results, the CMA reported that 90 to 95 per cent of Canadian women are at least somewhat satisfied with their obstetrical care. It viewed this as "conclusive evidence" that Canadian women have a high level of satisfaction with their obstetrical care. The dissatisfaction that existed related to a number of different factors. Satisfaction with pregnancy care dropped with increasing levels of education. Women who had seen an individual physician were more likely to be satisfied than those who had seen a group. Good communication increased satisfaction, as did the presence at labour and delivery of the physicians who had provided the woman's pregnancy care. More women were satisfied if their expectations for childbirth were met. The largest single reason for expectations not being met was medical complications, but other factors, such as hospital policies, the atmosphere during childbirth, and nursing and medical care increased the dissatisfaction among women whose expectations were not met. Women who had had a caesarean section, induced labour, or an enema were significantly less satisfied with their labour and delivery. Knowing why certain procedures were necessary and being given choices about procedures in childbirth increased satisfaction.

The CMA's conclusion that "the overwhelming majority of Canadian women who have given birth are very satisfied with the quality of obstetrical services they received" has been challenged. Louise Hanvey, Coordinator of the perinatal program at the Canadian Institute of Child Health, pointed out that women's statements about satisfaction may be misleading because the Canadian system of reproductive care does not offer women real choices in childbirth. Canadian women lack information about options that should be available to them (Hanvey, 1987).

Professor R.W. Osborne of the Department of Preventive Medicine and Biostatistics, Faculty of Medicine, University of Toronto, told the Task Force that in his opinion the data reported by the CMA are inconclusive. He said, "In its present form the report is worse than no information as it conveys a simple minded impression of contentment with the health care system which may or may not be what the respondents actually said."

The survey's authors themselves noted that several factors tend to diminish the amount of dissatisfaction women might otherwise report.

> First, patients may [not] easily admit to dissatisfaction with their personal medical care because of a general reluctance to question authority [*sic*]. Second, Sullivan

and Beeman have noted the existence of a 'halo' effect for mothers delivering a healthy baby. This outcome serves to diminish any negative feelings they may have experienced. Third, there is also the probability that in making an assessment of any kind of service, a consumer's judgment is facilitated by the existence of viable alternatives (Sullivan and Beeman, 1981). While there are indications that only a small percentage of Canadian women want an alternative (or perceive one as existing) to traditional obstetrical care, the lack of a basis for comparison or evaluation may have an impact. Finally, with the rapid declines in maternal and infant mortality following the rise in physician attended hospital births, most patients have taken a more passive role in the decision-making process. Content that risks have been averted and the chances of unfavourable outcomes reduced, it is probable that few women are disposed towards expressing dissatisfaction.

However, Sullivan and Beeman found that when preferences about specific procedures were not honoured, the level of satisfaction declined significantly. The conclusion was that the subtler distinction between the numbers of women reporting that they were very satisfied versus satisfied becomes very important as an indication of dissatisfaction.

Unfortunately, the results reported by the CMA did not distinguish between levels of satisfaction other than satisfied and dissatisfied.

Notes to Chapter 3

[1] Some occupations that provide health care are not currently regulated by provincial law. On April 3, 1986, the Minister of Health announced that the following groups will be regulated: audiologists, chiropodists, chiropractors, dental hygienists, dental technicians, dentists, denture therapists, dieticians, massage therapists, medical laboratory technologists, midwives, nurses, nursing assistants, occupational therapists, ophthalmic dispensers, optometrists, osteopaths, pharmacists, physicians, physiotherapists, podiatrists, psychologists, radiological technicians, respiratory technologists, and speech-language pathologists.

[2] Physicians are regulated by the College of Physicians and Surgeons of Ontario. Some of the professional associations include the Ontario Medical Association and the Canadian Medical Association, the Society of Obstetricians and Gynaecologists of Canada, and the College of Family Physicians of Canada.

Nurses are regulated by the College of Nurses of Ontario. Their professional associations include the Registered Nurses' Association of Ontario, the Ontario Association of Registered Nursing Assistants and the Canadian Nurses' Association.

[3] A small number of physicians are paid through alternative funding programs, rather than directly by OHIP on the basis of fee-for-service.

[4] Health Care Accessibility Act, 1986, S.O. 1986, c.20, s.2.

[5] Both general practitioners and family physicians care for patients of all ages and both sexes. For the sake of brevity we use the term general practitioner to mean both.

[6] Obstetricians are physicians who have completed four years of residency in obstetrics after medical school and internship. They are certified in their specialty by the Royal College of Physicians and Surgeons, a non-governmental certifying body. Obstetrics and gynaecology, the fields of medicine that specialize in the female reproductive system, are a single specialty. We use the term obstetrician, even though all obstetricians are also gynaecologists.

[7] In hospitals without obstetricians, general surgeons are called to perform caesarean sections if attempted vaginal deliveries fail and if the attending general practitioners need assistance.

[8] Ontario's birthrate is currently 14.6. This is approximately one-half the birth rate of 30 years ago. Between 1979 and 1984, the number of physicians grew by 13.5 per cent, from 15,307 to 17,367, and the physician to population ratio changed from 1:555 to 1:515. (Source: Ministry of Health, unpublished paper on Ontario health care system, November, 1986.)

[9] The 1987 fees to the Canadian Medical Protective Association were set at $800 for a general practitioner who does not practise obstetrics, and $1675 for one who does.

[10] Registered nurses who are educated at programs based at universities and Ryerson Polytechnical Institute hold baccalaureate degrees in Nursing. The basic or "generic" baccalaureate program lasts four years; shorter programs exist for registered nurses with diplomas to upgrade their qualifications. Diploma programs, lasting two to three years depending on how courses are organized, are operated at the CAATs. The majority of registered nurses hold diplomas. Registered nursing assistants are trained at CAATs in programs of 36 to 40 weeks duration.

[11] Public health nurses are registered nurses whose education included public health nursing, either within a degree program or in a separate program taken after a diploma program.

[12] Every municipality or regional municipality is required by provincial law to appoint a board of health, headed by a medical officer of health. The boards operate many public health programs, ranging from family planning and sexually transmitted disease clinics to inspection of restaurants.

[13] The Medical Services Branch of Health and Welfare Canada is responsible for health care for native Canadians living in all parts of Ontario. Where the provincial health care system is accessible, the Branch facilitates use of it rather than providing direct care.

[14] Many European countries and the U.S. have also regionalized obstetrical services.

[15] Shaving the woman's pubic area before the birth is a traditional hospital practice that has proven to be of no benefit.

[16] The benefit of using enemas and suppositories to empty the bowels before birth has been challenged. Routine shaving, enemas and suppositories are sources of discomfort and indignity for women.

Chapter 4

The Midwife's Scope of Practice

Purpose of the Chapter

In this chapter we address the midwife's role and function in the health care system — her scope of practice and how she relates to other caregivers. A profession's scope of practice encompasses the activities its practitioners are educated and authorized to perform. The actual scope of practice of individual practitioners is influenced by the settings in which they practise and by the needs of their patients or clients. But the overall scope of practice for the profession sets the outer limits of practice for all practitioners.

Perhaps surprisingly, it is often difficult to outline a profession's scope of practice with any precision. Some governing bodies have precisely outlined the scope of their profession's practice; others have not. Nevertheless, despite the inconsistent and often vague way in which it is described, scope of practice is important. It is in relation to scope of practice that governing bodies prepare standards of practice, educational institutions prepare curricula, and employers prepare job descriptions. Consumers, too, need at least a general understanding of scope of practice to know who is qualified to provide different kinds of services.

Health Professions Legislation Review

The *Health Disciplines Act* and other legislation do not define the scopes of practice of the regulated professions in a consistent way. The Health Professions Legislation Review has proposed that a uniform approach to describing scope of practice be taken by every regulated health profession. Every profession has been asked to develop a description of the broad range of its professional activities, including why and how the activities are performed. The professions have also been asked to prepare lists of acts that their members should be licensed to perform because these acts are potentially harmful if performed by people with insufficient training. If the Review's proposals are implemented, these descriptions and lists of licensed acts will be refined and incorporated into the new health disciplines legislation. Every profession's scope of practice may then be more precise.

Definition of Midwife

We begin our discussion of the midwife's scope of practice with a definition of what midwifery is or should be.

The Task Force recommends that Ontario enact a Midwives Act in which the midwife's scope of practice is defined consistently with the following international definition:

> **A midwife is a person who, having been regularly admitted to a midwifery education program, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery;**
>
> **Sphere of practice: She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the patients but also within the family and community. The work should involve antenatal education and preparation for parenthood, and extends to certain areas of gynaecology, family planning and child care.**
>
> **She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service.**

This definition was adopted by the International Confederation of Midwives and the International Federation of Gynaecologists and Obstetricians, in 1972 and 1973 respectively. It is now used by the World Health Organization. We think it captures the essence of the midwife's role and function and appropriately delineates her sphere of practice. The key elements of the definition are discussed in detail in this chapter.

The Midwife's Clients

Although the international definition does not explicitly refer to "normal", "healthy", or "low risk" pregnancies, it is universally acknowledged that the midwife is a specialist in "normal" reproductive care. Her primary client group is women with healthy, low risk pregnancies, for whom labour and childbirth without complications are predicted. Women whose pregnancies pose risks for themselves or their foetuses are appropriately cared for by medical specialists. Care in hospital of women with high risk pregnancies and complicated deliveries, and care of sick newborns, is within nursing's scope of practice. However, we do not recommend that midwives should be totally excluded from participating in the care of women whose health condition dictates that their care be managed by physicians. For example, even those women who expect to deliver their babies with obstetricians will benefit from a midwife's advice, counselling, and teaching. Furthermore, women whose social or economic circumstances cause or contribute to their risk status can especially benefit from midwifery care.

The Midwife's Activities

The basic elements of the midwife's activities are:

1. carrying out examinations necessary to establish and monitor normal pregnancies;
2. advising on and securing the examinations necessary for the earliest possible diagnosis of pregnancies at risk;
3. providing education and preparation for childbirth, including advice on exercise and nutrition;
4. caring for and assisting the mother during labour and monitoring the condition of the foetus by the appropriate clinical and technical means;
5. conducting spontaneous vaginal deliveries;
6. recognising the warning signs of abnormality in the mother or infant that necessitate referral to a physician;
7. taking necessary emergency measures in the absence of a physician;
8. examining and caring for the newborn infant;
9. caring for the mother in the postpartum period and advising her on infant care and family planning.

(adapted from European Community Midwives Directives Directive 80/155/EEC Article 4)

The midwife's activities can be classified as those relating to the assessment of client status or condition, those relating to the provision of care, and those relating to emergencies. These activities will be delineated in detail by the governing body for midwifery. The following discussion provides some examples of the midwife's activities but is not exhaustive.

Her activities relating to assessment of client status during pregnancy include obtaining the woman's medical, family, obstetric, social, and emotional history, and performing appropriate physical examinations such as pelvic and breast examinations. The midwife ensures that basic laboratory assessments, including blood tests and urinalysis, are performed. During labour, her activities relating to assessment of the client's condition include monitoring the foetal heart, abdominal palpation, and pelvic examination. After birth, they include performing the initial examination of the newborn and performing postpartum physical examinations of the mother.

The midwife's activities in the provision of care include providing comfort measures during pregnancy, labour and birth, conducting spontaneous vaginal births and delivering the placenta, performing and repairing episiotomies, and repairing first and second degree lacerations. The midwife administers routine medications on her own authority, including anti-haemorrhagic agents after birth for mother and newborn, local anaesthetics for use in repairing episiotomies and lacerations, and erythromycin or silver nitrate for the newborn's eyes. After the birth, she provides comfort measures for the mother, educates and counsels her on newborn care, and counsels her on family planning and contraception.

In emergencies, the midwife may administer CPR, and may provide initial treatment of prolapsed umbilical cord, haemorrhage, seizures, and foetal distress.

It is important to note that the midwife exercises independent clinical judgment within her scope of practice. She is responsible for the *management* of the pregnancies and births of the women under her primary care. As the international definition puts it, she conducts deliveries "on her own responsibility". The activities within the midwife's scope of practice are not delegated to her by physicians; rather the authority for performing them originates with her.

Some of the activities within the midwife's scope of practice, such as education and counselling on family planning, can be performed independently of the reproductive cycle. In some jurisdictions midwives do provide care to women outside the reproductive cycle. Privately practising CNMs in the U.S. sometimes provide well-woman gynaecological care (e.g., annual examinations, Pap tests); we even met a CNM who was making a specialty of treating women who suffer from Pre-Menstrual Syndrome. Well-woman gynaecological care is now provided in Ontario by physicians, and no evidence was presented to us that there is a need for midwives to participate in the provision of gynaecological care in any significant way.

The Task Force recommends that the activities within the midwife's scope of practice relate primarily to the reproductive cycle.

In practical terms, this means that with any one client, the midwife's services will begin during early pregnancy and will terminate at about six weeks after birth.

Delegated Medical Acts

As discussed above, each profession has a scope of practice. The physician's scope of practice includes many activities known as medical acts which may not ordinarily be performed by non-physicians. For example, a nurse may not conduct a delivery. However, the *Health Disciplines Act* provides a mechanism for the delegation of medical acts to non-physicians. The delegated acts are in addition to the acts ordinarily within the delegate's scope of practice. For example, it is within the nurse's own scope of practice to administer an injection ordered by a physician, but to start an intravenous line she requires delegated authority. The College of Physicians and Surgeons of Ontario (CPSO) may make regulations "authorizing persons other than members to perform specified acts in the practice of medicine under the supervision or direction of a member."

The Council of the CPSO, in consultation with the College of Nurses, the Registered Nurses' Association of Ontario, the Ontario Hospital Association, and the Ontario Medical Association, has issued a Policy and Guideline for the Delegation of Acts in the Practice of Medicine to nurses. Only acts specified in the Policy may be delegated, and there are provisions to ensure the nurses' competence to perform them. A number of obstetrical acts may currently be delegated, including performance of a vaginal examination during labour. The CPSO has also approved the delegation of medical acts to paramedics in emergency situations.

In addition to issuing general authorizations for delegation of medical acts, the CPSO's Advisory Committee on Special Procedures also approves delegations in particular circumstances. In this way nurses working in the Chedoke-McMaster Nurse-Midwifery Project have been authorized to perform such medical acts as episiotomy, delivery, and initial assessment of newborns.

Whenever a medical act is delegated, a physician remains responsible for supervising or directing the performance of the act by the delegate.

Some of the obstetrical acts now delegable to nurses are within the scope of practice we propose for the midwife and she will therefore not need delegated authority to perform them. However, there are acts outside the scope of practice we recommend for the midwife which she can usefully perform for a client even after a physician has assumed responsibility for care. An act appropriate for delegation might be regulation of the amount of intravenous medication being used to initiate or stimulate labour.

The Task Force recommends that provision be made for the delegation of medical acts to midwives.

Which medical acts may be delegated, and the circumstances in which they may be delegated, will be a matter for the governing bodies and professional associations of the two professions and the Ontario Hospital Association to determine in consultation with each other. If the Health Professions Legislation Review proposes the abolition of delegated medical acts, a different mechanism should be identified for extending the midwife's scope of practice in appropriate circumstances.

Notwithstanding this recommendation, we are concerned that excessive delegation of medical acts could lead toward midwives having more competence with technology at the expense of clinical skills involving direct patient care. In a World Health Organization report entitled *Having a Baby in Europe*, the authors observed this tendency as well as a tendency for midwives in or attached to hospital obstetrical units to become "physicians' assistants". These tendencies were observed even in European countries with a comparatively strong tradition of midwifery as an autonomous profession. For example:

> Midwives have always been skilful at evaluating during labour and birth the quality of the foetal heart tones as well as the rate, a skill that is invaluable in differentiating between foetal stress and foetal distress. With the advent of the electronic foetal monitor this skill is being lost. The midwife sometimes no longer sits with the woman in labour but at a desk monitoring one or more electronic foetal monitors. (WHO 1986, p.93-94)

The Task Force recommends that the governing body for midwifery be vigilant to ensure that delegation of medical acts is used sparingly so that it does not produce more competence with technology at the expense of clinical skills.

Mandatory Medical Visits

The midwifery care systems that we investigated in other jurisdictions require that women be seen by physicians at prescribed times during their pregnancies. For example, the new Danish Guidelines for Pregnancy, Hygiene and Perinatal Assistance prescribe medical visits as early as possible in the pregnancy, at 26 and 35 weeks, and at the first and ninth weeks after the birth. In The Netherlands, a pregnant woman visits her general practitioner when she thinks she is pregnant, both for confirmation of the pregnancy and for assessment of whether she should be cared for by a midwife or obstetrician. The midwives currently practising in Ontario ask their clients to visit a physician at varying intervals during pregnancy.

The Task Force recommends that the standards of practice for midwives incorporate a minimum of two mandatory medical visits during pregnancy. We recommend that the first mandated visit be as early in the pregnancy as possible, and that the second be at 32 to 34 weeks.

The purpose of the first visit is for the physician to conduct a physical examination and take a complete history in order to diagnose any medical problems and to assess whether the woman may appropriately be cared for by a midwife. If the woman has an established relationship with a physician, she may visit him or her even before she arranges to visit a midwife. If, however, the woman's first visit to a midwife precedes any medical visit, the midwife must direct the woman to visit a physician. The purpose of the second medical visit is to check the woman's overall health condition and to review the status of her pregnancy. The medical visits will also provide access to prescription medications, tests, services, and procedures for which the authority of a physician is required.

The Task Force recommends that there be a third optional visit during the course of the pregnancy, at a time considered appropriate by the midwife, the physician involved in the case, or the woman herself. We recommend that additional medical visits, for which there is no actual need, be discouraged.

Such additional visits should be avoided to prevent duplication of effort and the ensuing unnecessary costs. There should, of course, be no limit on necessary medical visits, or visits for conditions unrelated to the pregnancy.

We are aware that some physicians are concerned that mandatory medical visits may convey the impression that responsibility for care is being shared and that this may have adverse liability consequences for them. While we are mindful of this concern, we believe that two medical visits during pregnancy are in the best interests of the mother and foetus. The medical profession has already addressed the issue of demarcating responsibility for care between general practitioners and specialists in consultation and referrals. The protocols to be developed by the governing body for midwives in consultation with the CPSO will similarly demarcate the responsibility between midwives and physicians in regard to mandatory medical visits, consultations and referrals.

Consultations and Referrals

Although a pregnant woman may initially be suitable for primary care by a midwife, complications may develop that change this. Or it may be appropriate for the midwife to continue to care for the woman, but in consultation with a physician.

The Task Force recommends that the standards of practice for midwives include criteria for consultations with and referrals to physicians. We recommend that the governing body for midwives prepare these standards of practice in consultation with the College of Physicians and Surgeons of Ontario, the Society of Obstetricians and Gynaecologists of Canada and appropriate experts in the disciplines of medicine and midwifery. The standards should clearly differentiate between consultations for advice, consultations for advice and treatment, and transfers of care.

The Ontario Antenatal Record now provides guidance to physicians about the circumstances calling for referrals and consultations. Pregnancies that the Record classifies, according to various criteria, as Grade A are at no predictable risk. Pregnancies classified as Grade B may be at risk for the mother or foetus, and the physician is directed to consider consultation with a specialist obstetrician or internist; a Grade B pregnancy may be managed collaboratively in an obstetrical unit with intermediate level nursing facilties, or the woman may be returned for care to the referring physician with a suggested plan of management. Pregnancies classed as Grade C are at high risk, having complications that obviously endanger the foetus or the mother. Women in this category are recommended for transfer to a Level III perinatal centre for intensive care and delivery.

Midwifery services such as the Chedoke-McMaster Nurse-Midwifery Project have protocols that cover consultations and referrals. The Task Force obtained protocols from several U.S. midwifery services and the list of medical indications for specialist care used in The Netherlands. The latter appears in Appendix 6. The Association of Ontario Midwives also has a protocol to guide its members.

The consultations and referrals to be mandated by the midwives' standards of practice will not be the only contacts midwives and their clients have with physicians. We discuss in Chapter 5 the importance of integrating midwifery care into the health care system through practice settings in which midwives have regular contact with physicians. We think that informal relationships among midwives, general practitioners and obstetricians that transcend particular practice settings will evolve naturally as these practitioners become more familiar with each other.

The Task Force recognizes that the standards of practice regarding referrals and consultations will be effective only if physicians and midwives are willing to cooperate with each other. Working relationships between midwives and physicians must be such that necessary consultations and referrals are encouraged and easily carried out, while unnecessary or inappropriate consultations, referrals and self-referrals are discouraged. We anticipate that rigorous educational preparation for midwives, exacting practice standards, and adequate insurance coverage for midwives will facilitate collaborative attitudes between the two professions. On the basis of our consultations with individual midwives and physicians, and with their organizations, we are optimistic that a climate of true collegiality between the two professions will develop in Ontario.

Recommendations in this Chapter

1. **The Task Force recommends that Ontario enact a Midwives Act in which the midwife's scope of practice is defined consistently with the following international definition:**

   A midwife is a person who, having been regularly admitted to a midwifery education program, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery;

Sphere of Practice: She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the patients but also within the family and community. The work should involve antenatal education and preparation for parenthood, and extends to certain areas of gynaecology, family planning and child care.

She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service.

2. The Task Force recommends that the activities within the midwife's scope of practice relate primarily to the reproductive cycle.
3. The Task Force recommends that provision be made for the delegation of medical acts to midwives.
4. The Task Force recommends that the governing body for midwifery be vigilant to ensure that delegation of medical acts is used sparingly so that it does not produce more competence with technology at the expense of clinical skills.
5. The Task Force recommends that the standards of practice for midwives incorporate a minimum of two mandatory medical visits during pregnancy. We recommend that the first mandated visit be as early in the pregnancy as possible, and that the second be at 32 to 34 weeks.
6. The Task Force recommends that there be a third optional visit during the course of the pregnancy, at a time considered appropriate by the midwife, the physician involved in the case, or the woman herself. We recommend that additional medical visits, for which there is no actual need, be discouraged.
7. The Task Force recommends that the standards of practice for midwives include criteria for consultations with and referrals to physicians. We recommend that the governing body for midwives prepare these standards of practice in consultation with the College of Physicians and Surgeons of Ontario, the Society of Obstetricians and Gynaecologists of Canada and appropriate experts in the disciplines of medicine and midwifery. The standards should clearly differentiate between consultations for advice, consultations for advice and treatment, and transfers of care.

Chapter 5

THE FRAMEWORK OF PRACTICE

Purpose of the Chapter

In this chapter we discuss where midwives should work: practice models, which are the organizational frameworks and work settings within which midwives function. The midwife's employment status, how she is paid, with whom she practises and who is ultimately liable if she acts negligently are all components of the model of practice.

The Task Force believes that midwifery can be practised effectively in a variety of practice models. Some models may better suit some communities, some may be especially attractive to some midwives. Midwives, community agencies, and other potential employers should be free to choose the practice models that best meet their needs. The important thing is that every practice model be structured to maximize the safety and effectiveness of midwifery practice. We therefore begin the chapter with a discussion of the characteristics of safe and effective practice. Next we outline various models of practice, highlighting their potential advantages and disadvantages. Then we discuss four issues that arise in relation to all practice models: approval to practice, payment, hospital privileges and insurance. We conclude the chapter with a discussion of home birth.

Characteristics of Safe and Effective Midwifery Practice

The Task Force recommends that all midwifery practices display the following characteristics:

a. ***Continuity of care is provided.*** **Ideally, the midwife who cares for the woman during her pregnancy should be the one to attend her in labour and childbirth and provide her postpartum care. This is possible only if the midwife's actual scope of practice encompasses every stage of the reproductive cycle, that is, if her job or practice includes pregnancy care, labour and childbirth care, and postpartum care. It may be more practical in some settings for a group of midwives to share a woman's care. They can provide a sufficient measure of continuity if the group is kept small, if caseloads are assigned carefully, if every midwife in the group shares a common philosophy of care, and if every midwife is aware of the woman's special needs and preferences.**

b. ***The midwife's responsibilities include counselling, education, and emotional suppport.*** **Attention to women's psychological and social needs is an essential component of midwifery care. Women must also be well informed so they can make knowledgeable decisions about their care. Caseloads should be assigned and appointments scheduled so that a rapport can develop between midwife and client. The woman should have ample opportunity to ask questions, air her anxieties and express her preferences for childbirth. There should be time for her to develop confidence in the midwife or midwives who will be caring for her in labour and childbirth.**

c. ***The midwife has access to both institutional and community settings.*** **Wherever her practice is based, the midwife should be able to provide care in a variety of locations. Midwives based in hospitals and birthing centres should be able to provide care in community settings, and midwives based in the community should be able to provide labour and childbirth care to their clients in hospitals.**

d. ***The midwife has arrangements with physicians for consultation and referral and for ordering medications, tests, and procedures.*** **For midwifery care to be safe as well as effective, the midwife must be able to consult with general practitioners, obstetricians, and other other medical specialists easily, and to make referrals to them readily. Physicians must be available within a very short time if complications develop during labour and childbirth. Practice protocols should set out the circumstances in which consultation and referral are required.**

e. ***The midwife practises autonomously within her scope of practice.*** **Other caregivers must respect the midwife's autonomy. They must not interfere with her ability to manage pregnancy, labour and childbirth, and postpartum care.**

f. ***The midwife focusses on low risk pregnancies and normal childbirth.*** **The midwife should specialize in the care of women with uncomplicated pregnancies, for whom a normal labour and birth are anticipated. In some cases, however, exceptions can be made to this principle, because of the attributes of midwifery care and the needs of particular women. For example, midwives can work effectively with physicians in caring for women whose pregnancies carry risks; such arrangements may be desirable for immigrant women from cultures where most birth attendants are female. It has also been demonstrated that adequate pregnancy care improves the outcomes for young and socially disadvantaged women (Arms, 1975).**

g. ***The midwife has an opportunity to engage in continuing education and peer review.*** **These activities help the midwife maintain her competence. Arrangements with other midwives may be necessary to facilitate absences from the practice. The**

midwife should have access to other midwives and structured opportunities to review cases.

h. ***The midwife's working conditions are reasonable and she is fairly paid.*** **Continuity of care should not be at the expense of the midwife's private and family life, and the pace of work should not lead to rapid burn-out. This may require imaginative and flexible scheduling of work and time off. The remuneration paid to midwives should fairly reflect their level of responsibility, the demands on their time, the difficulty of their work, the cost of participating in continuing education activities, and the cost of professional liability insurance.**

i. ***The practice is responsive to consumer needs and preferences.*** **Women who have used midwives described to the Task Force how their midwives adjusted to their needs and preferences, rather than the other way around. Responsiveness to consumer needs and preferences may be more easily achieved outside institutions. Within institutions, formal mechanisms should be developed to enable midwives to listen to their clients and adjust their services to meet their needs.**

j. ***The practice continuously evaluates its effectiveness.*** **Measures of effectiveness of midwifery care include intervention rates, morbidity (illness), mortality, and client satisfaction. Practices should have ongoing programs of quality assurance, and costs should be monitored. Institutional practices may have in-house resources to design and implement evaluation programs, while private practices may have to consult with outside researchers, such as those based in universities. The results of the evaluations should be widely disseminated as they will be valuable in making improvements to policy, education and practice.**

k. ***The care provided is cost-effective.*** **Each midwife should render an appropriate volume of service, and the number of hours of care allocated to each client should be neither inadequate nor excessive. Women should be discouraged from going to physicians (or other midwives) to obtain care that unnecessarily duplicates the care provided by their primary midwives.**

These characteristics will play an important role in the approval and funding mechanisms discussed later in the chapter.

Models of Practice

In this section we discuss several practice models which might be used in Ontario.

Hospital Employment

In this model of practice, the midwife is employed by the hospital to provide care to women who are clients or patients of the hospital. The hospital pays the midwife a salary out of its operating budget and is responsible for the midwife's actions.

Hospital practice can take various forms. One form we would not endorse is the restricting of midwives solely to staffing labour and delivery services where they provide care that would otherwise be provided by obstetrical nurses, and conduct uncomplicated deliveries on behalf of absent physicians. The defects of such a form of practice include a complete lack of continuity of care and a limited scope of practice.

The Chedoke-McMaster Nurse-Midwifery Project, described in Chapter 3, represents another model of hospital midwifery practice. There, a small group of midwives provides comprehensive pregnancy, labour, and childbirth care to healthy women with uncomplicated pregnancies. Continuity of care is interrupted because the midwives are assigned to either the prenatal clinic or the labour and delivery unit, and because little postpartum care is usually provided. These weaknesses are largely attributable to the absence of specific funds for midwifery services and could therefore be remedied.

A "Know Your Midwife" clinic at St. George's Hospital in Tooting, South London, provides a model of continuous midwifery care from pregnancy through the postpartum period (Flint, 1985). The clinic is run by a group of four midwives. They provide all pregnancy care except for an initial visit with a physician, in order to assess the woman's risk status and suitability for midwifery care, and a consultation with an obstetrician at the 36th week of pregnancy. Most prenatal appointments take place in the hospital, but at least one home visit is made. One of the four midwives cares for the woman in hospital during labour and childbirth, and members of the group visit her twice a day during her stay in hospital after the birth. After she and the baby are discharged from hospital, the midwives make home visits, provided the home is within the hospital's catchment area. The clinic is a good example of continuity of care being provided by a small group of midwives.

Several hospitals made submissions to the Task Force in which they outlined proposals to establish midwifery services. Women's College Hospital in Toronto proposed several different types of practice, including an alternative birthing centre in which the role of primary caregiver would be shared by midwives and general practitioners (or assigned to one or other of them) and backup obstetricians, neonatologists and paediatricians would be available for consultation and in the event of an emergency. Scarborough Grace General Hospital proposed that midwives work in an outpatient clinic, obtaining patients on referral from general practitioners. The midwives would follow their patients through pregnancy and, through a system of on-call coverage, would try to attend them in labour and childbirth.

Hospital midwifery practice offers several potential advantages. The midwife has easy access to laboratory services and procedures. General practitioners, obstetricians, and other medical specialists are readily available for consultations and referrals and for prescribing medications. The full range of hospital services is present in the event of an emergency. Assuming, as seems likely, that the hospital employs a group of midwives rather than a single midwife, it should be possible to schedule work to afford each midwife a private life and time off to engage in continuing education and other professional activities. Each midwife has colleagues for peer review. It is possible for the midwives to work without obtaining primary liability insurance coverage, because the hospital will carry insurance and will be vicariously liable for their negligent acts. The costs of hospital practice are controllable through limits on the hospital's operating budget. Hospitals may have resources to conduct evaluations of the effectiveness of their practices. Community hospitals, as opposed to Level III hospitals whose obstetrical services are geared to high risk women, may be particularly hospitable to midwives because they are specialists in normal cases. Finally, hospital based practices may appeal to some women because of the presence of hospital facilities and physicians.

For hospital midwifery to be effective, however, the administrators and the medical and nursing staffs must be committed to making it so. There is no doubt that introducing a midwifery service will pose organizational challenges. Each hospital will have to make decisions about reporting responsibilities and accountability: to whom in the hospital hierarchy should midwives report? to whom should they be accountable? The Ontario Hospital Association (OHA) suggested that midwives could report, through the director of midwifery services, to the chief executive officer of the hospital or an executive vice-president for administrative purposes, and to the head of the department of obstetrics and gynaecology for clinical purposes. The Ontario Medical Association Committee on Hospitals suggested that if the medical staff organization is to be assigned primary responsibility for advising the hospital board on midwifery practice and quality assurance issues, then midwifery could be a service under the department of obstetrics and gynaecology. The service would be headed by a midwife, who would be responsible for the care given by the midwifery staff and would report to the chief of the department. The chief would be accountable to the Medical Advisory Committee. The Committee felt that the model proposed by the OHA would also be feasible. No doubt individual hospitals will devise arrangements that suit their needs.

The nursing and midwifery staffs will have to adjust to each other, because the scopes of practice of the two professions overlap. Common sense will have to be applied to sort out such everyday issues as responsibility for checking blood pressures in the labour and delivery room. Protocols and standing orders will have to be prepared so that midwives can function effectively, autonomously, and safely, while complying with the *Public Hospitals Act*.

Both the OHA and several individual hospitals expressed particular concern about midwives who are employees being permitted to provide care off hospital premises. Their concern relates to the hospital's legal liability if the midwives attend at home births. The safety of home birth and how insurance coverage might be obtained for hospital-employed midwives who attend home birth, are discussed later in this chapter. In our review it is essential that midwives based in hospitals be permitted to attend home births.

Midwives employed in hospitals must also be able to make postpartum home visits. This may pose an organizational challenge because prenatal appointments must also be scheduled and the hospital must be "covered" if a midwifery client goes into labour. At the same time, continuity of care must be preserved and costs kept down. Hospital midwifery services like the "Know Your Midwife" Clinic described above show that the challenge can be met.

The Task Force recommends that midwives work in hospital midwifery services that meet the requirements for safe and effective midwifery practice.

Employment in a Birthing Centre

On March 13, 1987, the Minister of Health announced that his Ministry will provide funds to establish three hospital-affiliated birthing centres in Ontario. One is to be located in Toronto, one in Ottawa, and one in Northern Ontario. The purpose of the birthing centres is to "create an environment that is homelike, private, comfortable and relaxed." The birthing centres will offer limited obstetrical intervention. Families may choose early discharge, and there will be minimal separation of parents and newborn infants.

Birthing centres appear to be natural practice settings for midwives. Members of the Task Force visited freestanding and in-hospital birthing centres in Europe and the U.S. in which midwives are the primary caregivers. The birthing centres appeared to be very popular with women and seemed to provide an unconfining environment for effective midwifery practice.

In terms of organization, employment in a birthing centre would be very similar to employment in a hospital, except that the small size of the birthing centre would likely simplify matters. With respect to care in the community, it would be desirable for the midwives to make postpartum home visits.

The Task Force recommends that midwives work in birthing centres that meet the requirements for safe and effective practice.

Employment in a Community Health Centre

In Chapter 3, we described community health centres (CHCs). Physicians and nurses now working in CHCs provide limited pregnancy care. However, since CHCs do not currently provide obstetrical or other specialist services, women are referred to other physicians or hospital obstetrical clinics at a certain point in their pregnancies, and the CHC staff play no role in their care during labour and childbirth.

The Association of Ontario Health Centres and the West Central Community Health Centres in Toronto told the Task Force that CHCs are appropriate practice settings for midwives. We agree with this view. Midwives would benefit CHCs by helping them to establish and consolidate client bases of pregnant women, new mothers and their children. The general practitioners who work in CHCs and the medical specialists with whom they have links would be available for consultation and referral, for ordering tests and procedures, and for prescribing medication. CHC physicians and nurses are accustomed to scheduling appointments so that there is time to talk with patients. The ethos of the CHC, which recognizes the importance of addressing clients' social needs, may make them especially hospitable settings for midwives. The costs of midwifery care in this setting would be controlled through the global operating budget paid by the Ministry of Health.

The Task Force recommends that the Ministry of Health expand the mandate of the Community Health Centre program to permit Community Health Centres to employ midwives, provided the requirements of safe and effective practice are met.

However, the CHC setting is not without drawbacks. We were told that it is unlikely that the current clientele of any CHC includes a sufficient number of pregnant women to warrant full-time employment of one midwife. While a midwife could be employed on a part-time basis, this might raise problems of continuity of care. Intitially, it might be practical for two or more CHCs to share the service of one full-time midwife, or of a small group of part-time midwives.

Finding a setting where CHC midwives can attend their clients in labour and birth may pose a greater problem. The problem is identical to that faced by midwives in other community-based practices: gaining access to hospital birthing facilities. We discuss this issue later in this chapter.

Making postpartum home visits to clients should pose only an organizational challenge to CHCs. It would be open to the board of each CHC to decide if it wished to offer a home birth service. Any additional liability insurance costs occasioned to the CHC by the home birth service could be either included in the CHC's operating budget and paid by the Ministry of Health or passed on to clients using the service.

Employment by Board of Health

The mandate of municipal boards of health includes the provision of family health services and programs. These are defined by the *Health Protection and Promotion Act, 1983* to include counselling services, family planning services, programs to identify pregnant women in high risk health categories, and health services to infants and women in high risk health categories. Public health nurses assess pregnant women for risk, make the appropriate referrals to physicians and to community and hospital clinics, and provide any necessary follow-up and counselling. Their clientele for these services includes women referred by other community agencies and women identified through other board programs. Public health nurses also administer and work alongside physicians in family planning clinics and make home visits to some pregnant and postpartum women. Boards of health do not provide primary care to pregnant women apart from counselling; rather, their focus is to facilitate access to physicians.

Midwives will have the qualifications to provide the services to pregnant women, new mothers, and babies now provided by public health nurses, but we have reservations as to whether these services would make the best use of midwives' special expertise. We find a model proposed by the City of Toronto Department of Public Health more attractive. The city has proposed a pilot project in which the Department would employ midwives. A hospital, community health centre or group medical practice would be involved in the project. The midwives would be affiliated with a medical practice whose members have hospital admitting privileges, preferably at a teaching hospital. Ideally, the midwives would have hospital privileges; alternatively, arrangements might be made whereby the midwives were formally affiliated with both the Department and a hospital. All births would be in hospital. The project would offer family-centred care to physically healthy women throughout the reproductive cycle, and would stress continuity of midwifery care. It would target clients who, though physically healthy, are at risk because of psychological or social factors.

Employment with boards of health offers many of the same advantages as employment with other institutions. Costs are controllable through the board's operating budget. The municipality will be responsible for maintaining insurance coverage for the midwives' activities. Boards of health have the knowledge and experience to identify potential client groups that would especially benefit from midwifery care, as well as the resources to plan, implement, and evaluate their services.

However, in our view, it is unlikely that boards of health can provide effective direct midwifery services without involving other caregiving agencies or individuals. The physicians who head the boards (medical officers of health) are unlikely to have the experience or time to provide medical backup nor do they ordinarily have hospital privileges. Jointly run projects such as that proposed by the City of Toronto Department of Public Health appear to hold greater promise.

The Task Force recommends that midwives work in services sponsored by boards of health that meet the requirements for safe and effective midwifery practice.

Private Practice

In this model of practice, the midwife is a self-employed professional whose business is the provision of midwifery services to a clientele. She may practise alone or as part of a group. The practice is likely to be based in community premises such as an office building, storefront, or house. There the midwife gives pregnancy and postpartum care to her clients.

The advantage of private practice to the midwife may lie in the control she has over her working conditions. She decides which (and how many) clients to accept, and she schedules her own hours of work. She creates the atmosphere of the practice.

Private practice may be attractive to some clients as well. For most people, it is the most familiar way of obtaining health care. Some people prefer to avoid institutions like hospitals. Privately practising midwives may take midwifery services to areas of Ontario where no hospital, board of health, or CHC wishes to employ midwives or is able to do so.

The Task Force recommends that midwives work in private practices that meet the requirements for safe and effective midwifery practice.

Private practice raises issues relating to approval to practise, payment mechanisms, insurance and access to birthing facilities. These issues are addressed later in this chapter.

Practice with Physicians

The model of private practice described in the preceding section includes the possibility of group practice involving both physicans and midwives. Obstetricians and general practitioners in private practice may wish to bring midwives into their practices. They may wish to share a primary care caseload, or to involve midwives in the care of women with high risk pregnancies.

Co-practice arrangements with physicians will facilitate consultation and the ordering of tests, procedures and prescription medication. The midwife can use the general practitioners' links with obstetricians and other medical specialists if the practice itself did not include these specialists. The medical practice's roster of patients will provide a client base for the midwife, and she will attract new patients to the practice. However, a single midwife might find it difficult to provide continuity of care, particularly if the physicians in the practice do not provide obstetrical care. Access to birthing facilities will have to be arranged. This issue, as well as how co-practice arrangements should be authorized and funded, is discussed later in this chapter.

The Task Force recommends that midwives and physicians work together in practices that meet the requirements for safe and effective midwifery practice.

Approval to Practise

The Task Force believes that there should be a mechanism to ensure, as far as possible, that midwifery practice models provide safe and effective care. The mechanism should exist in addition to the regulation of qualifications for practice, standards of practice, and professional conduct provided by the governing body for midwives. It should apply to both institutional and community-based practices. We think it should enable the Ministry of Health to exercise control over the creation of new midwifery practices and to monitor their effectiveness. It should enable the Ministry to ensure, among other things, that each new practice will serve the needs of an identifiable clientele; that the midwives will have adequate links with physicians, hospitals, and possibly other community agencies; that the practice will offer continuity of care throughout the reproductive cycle; and that the practice will monitor and evaluate its effectiveness.

In particular, the mechanism should enable the Ministry to prevent midwives from practising entirely on their own, without links to the overall health care system. We believe that such a model of practice would be ineffective and potentially hazardous. Even though the midwife practising in an unintegrated practice would be a fully qualified member of the profession, regulated by the governing body, her knowledge and skills would not be supported by the structures that integration would provide. Opportunities for peer review and informal consultation with colleagues would be limited. Hospital and physician backup would be less than ideal. Furthermore, permitting such a model of practice would tend to create two types of midwife, one engaged in integrated practice with links to the community of other caregivers and hospitals, and one engaged in unintegrated practice, with home birth clients. This is precisely the situation that exists in the U.S. and we think Ontario should make every effort to avoid it.

The mechanism should also be used to prevent undesirable institutional models of practice, such as hospital services in which midwives are used as physician substitutes or stand-ins in conventional labour and delivery services. We specify this model as one to be avoided because it is impossible for it to provide effective midwifery care.

Finally, the mechanism could be used to further other government objectives that are not inconsistent with the provision of safe and effective midwifery care. For example, control over the location of new practices could be used to equalize access to midwifery care across Ontario.

The Task Force recommends that no midwife be permitted to practise except in a practice, service, agency or other health facility approved by the Ministry of Health.

We envisage an approval process analogous to that used by the Community Health Programs Branch of the Ministry in approving new CHCs. A group requesting approval to establish a CHC must make a submission to the Branch outlining who the proposers are (including their experience in providing, planning, or managing health services); the population to be served, its characteristics, and how the CHC will deal with such things as barriers to access and special health risks; a description of the program (including needs, objectives, process, service targets, content and evaluation methods); organization; and budget.

A midwife or group of midwives, a multi-disciplinary group that includes midwives and physicians, a physician practice, board of health, community agency, or hospital would approach the Ministry with a proposal to establish a midwifery practice or service. The accompanying submission would provide detailed information on all aspects of the proposed practice or service. The submission would describe its objectives, content, organization, target clientele, and how it will satisfy the requirements for safe and effective practice. All such proposals would be evaluated by the same branch of the Ministry, whose staff would acquire expertise and experience. It would not be desirable, in our view, for the Community Health Programs Branch of the Ministry to evaluate proposals to establish community-based practices while the Institutions Branch evaluated proposals to establish hospital midwifery services; it would, of course, be appropriate for these branches to be consulted. The Women's Health Bureau of the Ministry would be consulted to tap its expertise in women's health issues. The Ministry might also wish to consult with District Health Councils.

Because all practices and services will be required to monitor and evaluate their effectiveness, the same branch of the Ministry will have an objective basis upon which to decide whether approval should be continued from year to year. While cancellation or discontinuation of approval will have significant consequences for the practice's clients, and the practice should be given a fair opportunity to become established and to remedy its deficiencies, this ultimate sanction should nevertheless be available.

The Task Force recommends that a mechanism be established in the Ministry of Health for approving all institutional and community-based midwifery practices and services. We recommend that proposals to establish such practices and services be evaluated by a designated operational branch in conjunction with the Women's Health Bureau of the Ministry, and that approval be granted to proposed practices and services that meet the requirements for safe and effective midwifery practice. We recommend that the Ministry be empowered to discontinue or cancel approval if a practice or service fails to provide safe and effective midwifery care after a reasonable opportunity has been provided for it to do so.

We emphasize that individual midwives who wish to establish well integrated solo practices will be eligible for approval. Approval for such practices would be granted or withheld by the Ministry according to the same criteria used to assess other proposed practices and services — namely, the extent to which the practice will provide safe and effective midwifery care.

However, approval alone will not enable any proposed practice or service to become operational. Funding will also be required.

Payment for Midwifery Services

In announcing the decision to recognize midwifery as a regulated health profession and to integrate it into the overall health care system, the Minister of Health did not explicitly address whether midwifery services will be paid for by the province or by users. Virtually every individual consumer and consumer organization, as well as medical and nursing organizations, told the Task Force that the province should pay for midwifery services. This was also the view of midwives and midwifery organizations. Consumers and midwives said every woman is entitled to the important, basic health care service that midwives provide and that midwifery care should not be denied to less affluent women. They claimed that any apparent increase in the provincial health care budget due to midwifery services would be balanced by long-term savings resulting from midwifery.

We think midwifery will not be fully integrated into the health care system unless midwifery services are paid for by the province. The issue is: what is the appropriate payment mechanism for midwives? In the institutional practice models discussed above, midwives will be employees of institutions whose operating funds are substantially provided by the

Ministry of Health: indirectly, midwives' salaries will thus be paid for by the province. The matter is more complex for midwives working in non-institutional, community-based practices.

Some individuals and groups that addressed the issue of payment said midwifery services should be insured services under OHIP. As the OHIP Schedule of Benefits is currently structured, midwives would be paid for each service they rendered. Officials in the Ministry of Health expressed their concerns about including midwifery services in OHIP and paying midwives on a fee-for-service basis. They believe that including midwifery services in OHIP will increase the pressure on the Ministry from other professions to include their services in OHIP; this is undesirable from the point of view of the Ministry, which is being pressured to contain health care costs. Likewise, it feels that payment on the basis of fee-for-service would make it difficult for the province to control the overall costs of midwifery care.

The Association of Ontario Midwives is opposed to payment on the basis for fee-for-service calculated on a per-visit basis. It proposed that midwifery care be considered a single service package, compensated by a flat fee, or that midwives be salaried through OHIP. If salaried, they would be required to attend a minimum number of births.

The Task Force does not believe that payment on the basis of fee-for-service is an appropriate way of remunerating midwives. It is fundamentally inconsistent with the holistic philosophy of midwifery care. To itemize every unit of service, be it education, counselling, emotional support, or physical care, would run counter to the nature of midwifery care, in which the various aspects of care overlap and reinforce each other. Payment on the basis of fee-for-service may encourage the caregiver to provide a large volume of services, with resultant cost increases to the system. Furthermore, the caregiver may be able to increase her volume only by working faster and spending less time with each client or patient. From the payment agency's perspective, mechanisms for controlling fee-for-service costs are limited if the program undertakes to cover all "necessary" services. It is difficult to prove that some services were unnecessary; they can be detected only retrospectively and usually only if an aberration in the practitioner's billing pattern appears.

Payment on the basis of fee-for-service also necessitates the preparation of fee schedules. The preparation of a fee schedule for midwifery care would involve difficult comparisons with the fee schedule for obstetrical services rendered by physicians. We think this could easily be a continuing source of friction between midwives and physicians.

Since we reject payment on the basis of fee-for-service as an appropriate payment method, we see no reason to use OHIP as the payment mechanism or paymaster for midwives. It is true that OHIP could establish a global fee payable for comprehensive midwifery care. At one time such a global fee was paid to physicians for obstetrical services. However, to strike a global fee would again necessitate comparisons with physicians' services. Further, devices would have to be engineered to deal with such situations as transfers of care to another midwife or physician. A lesson can be drawn from The Netherlands, where midwives are paid a global fee per client. The health insurance program has been unable to devise a mechanism that is both safe and cost-effective for handling cases in which the midwife transfers care to a physician. The current mechanism results in substantial duplication in payment, while the mechanism it replaced tended to discourage midwives from making timely referrals.

The payment mechanism devised for midwifery services should apply to all models of community-based private practice, including those in which midwives are self-employed, and those in which they are employed by physicians or associated with them in other arrangements. Given the present structure of OHIP, physicians assigning responsibility for providing care to midwives employed by them would not be paid by OHIP for the services provided unless they also saw the client. This would make working arrangements with midwives inefficient and unremunerative.

This problem does not exist for those physicians who, instead of billing OHIP on a fee-for-service basis, receive global payments from the Ministry of Health based on "capitation". Physician practices funded in this way are called Health Service Organizations (HSOs). A relatively small number of physicians work in HSOs in Ontario, most of them general practitioners. The Ministry pays the HSO an amount for each patient enrolled on the HSO's roster; the amount reflects the patient's age and sex and the value of OHIP services consumed by an average person of the same age and sex. The amount is increased if the HSO provides specialist services. Out of the amounts paid by the Ministry, the HSO pays its operating expenses, including reumuneration to physicians and other staff. HSOs have an incentive to employ non-physician caregivers when it is efficient to do so and when these caregivers may attract more patients to the HSO. These caregivers could include midwives.

The Task Force received a submission from the East End Health Centre, an HSO in Toronto, expressing interest in involving a midwife in its practice. One of its two general practitioners now provides obstetrical care. It suggested that it would also add an obstetrician to its staff. The extra capitation funds generated by the practice would be shared between the obstetrician and the HSO, and the HSO would pay the midwife either on a salary or per-case basis.

The Task Force believes that all physicians, not just those working in HSOs, should have an opportunity to work with midwives. Funding mechanisms should be available to all physicians, regardless of the method by which they are paid for their own services.

The Task Force recommends that the Ministry of Health provide funding to approved institutional and community-based midwifery practices and services, including those proposed by individual midwives, groups of midwives, multi-disciplinary groups, boards of health, community agencies, physicians and hospitals. We recommend that funding be provided on the basis of global, program-based budgets.

For the practice or service to be eligible for funding, it must first be approved by the Ministry of Health in accordance with the mechanism already described. After obtaining approval, the staff or sponsors of the practice or service would submit a budget to the Ministry covering all operating costs, including the midwives' remuneration. The budget would then be negotiated with Ministry officials. The negotiations would take into consideration the requirements for safe and effective midwifery practice as well as overhead expenses, including malpractice insurance. The Ministry should not demand that the midwives' caseloads be so large that little counselling, education or emotional support could be provided to clients.

Although we have described a two-step process for obtaining Ministry approval and funding, in practice it may be possible to compress the process to make it less intimidating to potential applicants. It would be unfortunate — and, surely, unnecessary — if the process deterred worthy applicants.

The Task Force recommends that the Ministry of Health appoint a member of its staff to assist applicants in preparing and submitting applications for program approval and funding.

Although it might be desirable for every approved practice and service to obtain Ministry funding, the Task Force recognizes that this may not be possible. Sufficient funds may not be available to give financial support to every practice that obtains program approval in a fiscal year. Should these practices be permitted to charge their clients directly instead of obtaining Ministry funding? Or, if only partial Ministry funding is available, should they be permitted to charge their clients additional amounts?

The Task Force has considered the position of other health professions in relation to this issue. Since enactment of the *Health Care Accessibility Act, 1986* physicians in Ontario have not been permitted to charge their patients any amount for services insured by OHIP; they are permitted to charge them for uninsured services, such as cosmetic surgery. Dentists and optometrists work under the same restriction with respect to their insured services. Nurses and chiropodists who engage in private practice may charge their patients for their services. The same services provided by nurses and chiropodists in institutional settings are not charged to patients and are paid out of the institutions' operating budgets. Some physiotherapists have OHIP billing privileges while others who do not may charge their clients directly.

We believe that the closest analogy to midwifery services is physicians' services and that midwives, like physicians, should not be permitted to charge their clients for midwifery care. Midwifery care should be equally accessible to all women; there should be no cadre of "elite" midwives catering to the minority of women who can afford to pay for their services themselves.

The Task Force recommends that midwives be prohibited from seeking or obtaining payment for midwifery services directly or indirectly from clients.

This prohibition is not intended to prevent midwives from charging fees for childbirth education classes. Midwives sometimes offer these classes to women who are not their clients as well as to those who are. Boards of health and community organizations usually charge fees for the childbirth education classes they provide. There is a clear difference between public education and direct client care, and we think that midwives, like boards of health and other agencies, should be entitled to charge for the former.

The Task Force recommends that midwives be permitted to charge fees for childbirth education classes.

Although the Ministry of Health may not be able to provide funding to a particular practice or service, a union, voluntary association, charitable foundation, or other organization may wish to do so. An organization of this kind may wish to establish such a service for its members or to serve a particular clientele of concern to it. It may wish to provide full or partial funding for the midwifery service. Provided the midwives in the service are to be paid at approximately the same rate as midwives in practices fully funded by the Ministry, and provided the organization does not propose to provide what is in reality private insurance for midwifery services, we have no objections to this. The service or practice would, of course, be subject to the full Ministry approval process to ensure that the requirements for safe and effective midwifery care are met.

The Task Force recommends that the Ministry of Health be empowered to permit organizations such as unions, voluntary associations, and charitable foundations to provide full or partial funding to approved midwifery practices and services.

Hospital Privileges

As was explained in Chapter 3, the *Public Hospitals Act* provides for the appointment of physicians to the medical staff of a hospital. A physician who is appointed to the staff has what are commonly referred to as hospital privileges, which ordinarily include the right to admit and treat patients in the hospital. The *Public Hospitals Act* makes no provision for appointing midwives to the hospital staff and, therefore, midwives cannot be granted hospital privileges. How, then, can midwives based in practices in the community gain access to hospital birthing facilities?

Since midwives can be hospital employees, a possible solution may be for them to be employed jointly by the community employer and the hospital. However, we think a more direct solution is necessary.

The Task Force recommends that the *Public Hospitals Act* and Regulations be amended to empower hospitals to appoint midwives to the hospital staff.

We are aware of the concern that making statutory provision for the appointment of midwives to the hospital staff may energize the efforts of other health professions to obtain hospital staff privileges. We were cautioned that it might be seen as unfair to give midwives — newcomers to the system — hospital privileges when much older groups have been denied them. Leaving aside arguments as to the "age" of the various professions, and without commenting on the strength of any other profession's case for hospital privileges, we think the arguments for enabling midwives to be granted privileges are compelling. If they do not receive privileges, midwifery will not be fully integrated into the health care system and public safety will be compromised.

The reality is that if midwives do not have access to hospital birthing facilities, their clients will be forced to choose between giving birth at home and giving birth in hospital with a birth attendant — a physician — who is not their preferred caregiver. In all likelihood, any physician who agrees to attend a woman's birth in hospital will insist on significant involvement in her pregnancy care, while the midwife who provided the woman's pregnancy care will want to be present at the birth to coach and support her in labour. In other words, there will be duplication in care and unnecessary costs to the health care system.

Second, denying women the caregiver of their choice in hospital — a bad principle to begin with — will not advance the policy of encouraging women to give birth there. On the contrary, it will encourge women to stay at home even if their health status makes hospital birth imperative. It will also encourage the development of a group of midwives whose practice is restricted to home births and who have minimal contacts with the overall system.

Throughout our Report we emphasize how important it is that midwives' work encompass the full scope of practice during every stage of the reproductive cycle. Continuity of care depends on this. We think it is nonsensical to construct a system in which highly qualified birth attendants are denied access to the childbirth setting used by 99 per cent of Ontario women.

The amendment we recommend will not force hospitals to pass by-laws providing for the appointment of midwives or, having done so, to make any appointments. We think compulsion is counter-productive: midwifery cannot flourish in a hostile environment. We also think that resistance on the part of hospitals will be overcome as specific implementation problems are solved, as administrators, physicians, and nurses become more familiar with well qualified midwives, and as midwifery care proves its worth and popularity.

We recognize that the procedure currently used for appointing physicians may appear to be unsuitable for the appointment of midwives. As we explained in Chapter 3, appointments are made by the hospital board on the basis of recommendations made by the Medical Advisory Committee (MAC). The MAC consists of representatives of the medical staff, that is, physicians. The qualifications of those who apply for hospital privileges are reviewed by the credentials committee, which also consists of physicians. After some consideration, we have rejected the idea of recommending the formation of a special committee to review the credentials of midwives who apply for privileges and to make recommendations about their appointments to the board. It will not be inappropriate for a hospital's physicians to participate in the process for considering applications from midwives, because the physicians and the midwives will work together. It is important to note that the hospital board, not the MAC, makes the actual decision on every application. Midwives denied privileges will have the right to appeal to the Hospital Appeal Board and to the Divisional Court. In time, there may be enough midwives on the hospital staff to make feasible the creation of a midwifery advisory committee or a joint medical/midwifery advisory committee.

The Task Force recommends that the *Public Hospitals Act* and the Regulations thereunder be amended to establish the necessary structures and procedures for appointing midwives to the staffs of hospitals.

While a full Ministry review of the *Public Hospitals Act* and Regulations will be necessary to identify all the provisions that will require amendment, we suggest that the necessary amendments to the Act include:

a) an amendment to extend the definition of "treatment" to include midwifery care;

b) an amendment to empower the board to appoint midwives to the midwifery staff established by the by-laws, to determine the privileges to be attached to each appointment, and to revoke or suspend an appointment or to refuse to reappoint a midwife;

c) an amendment to require the administrator to send a report to the midwives' governing body when an appointment is rejected, privileges are restricted or cancelled, or the midwife resigns, for reasons of incompetence, negligence, or misconduct;

d) an amendment to require a member of the hospital staff to take appropriate action when it appears that there is a serious problem with the midwife's care of a patient; and

e) an amendment to establish the procedure for processing applications from midwives, including the right to appeal to the Hospital Appeal Board.

The necessary amendments to the Regulations include:

a) an amendment to empower the board to pass by-laws that provide for the appointment and functioning of a midwifery staff;

b) an amendment to permit a patient to be admitted and discharged on the joint or several order of a midwife and a member of the medical staff;

c) an amendment to permit a midwife to write a history, make a physical examination and make and record a provisional diagnosis, within 72 hours of the patient's admission; and

d) an amendment to make provision for a midwife who is unable to perform her duties in the hospital.

Ideally, these amendments should be made at the same time as enactment of the Midwifery Act, so that a major obstacle to integration is removed and the way for midwives to care for their clients in hospitals is cleared from the beginning.

Insurance

It is important for midwives to obtain liability insurance to protect themselves and their clients against the consequences of any mistakes made while providing care. A mistake that causes harm to the mother or child may result in allegations that the midwife departed from the expected standard of care through negligence, and a claim for damages. Malpractice or liability insurance can protect the midwife from having to pay any legal or settlement costs that result from the claim. From the client's point of view the fact that the midwife is insured means that money will be available if anyone is harmed by the midwife's negligent acts or omissions. If the midwife is uninsured, a claim for damages could result in attachment of the midwife's personal assets, and in only partial payment of the settlement or damage award. Obviously this is not a desirable outcome for either the midwife or the client.

However, the integration of midwifery into the health care system comes at a time when the availability of professional malpractice insurance is restricted. Many professions have been faced with sharp increases in malpractice insurance premiums. The availability and cost of insurance for midwives was clearly an issue of concern to the midwifery, medical, nursing, and hospital groups that we consulted. Indeed, some of them felt that the lack of affordable insurance would be a limiting factor on the implementation of the Task Force's recommendations.

Task Force on Insurance

As a result of the Government's perception that Ontario was experiencing an acute insurance crisis, the Ontario Task Force on Insurance, chaired by David W. Slater, was appointed in January 1986. This Task Force investigated the causes and characteristics of the insurance crisis and made wide-ranging recommendations for resolving and coping with it. Two particular areas investigated by the Task Force were professional malpractice insurance and insurance in the health care sector. The Report of the Task Force on Insurance has been helpful to us in our consideration of insurance for midwives. Those of its findings and recommendations that are of particular relevance to liability insurance for midwives are reported in this chapter.

Current Pattern of Liability Insurance in the Health Care Sector

Hospitals

Hospitals carry liability insurance to protect themselves against claims resulting from the negligence of their employees. Traditionally, hospitals have not been held responsible for the negligence of independent practitioners such as physicians, who are allowed to practise in hospital but who are not employees. Some observers believe that this is changing; they say the law is now developing in the direction of holding hospitals responsible for the negligent acts of the physicians and other independent practitioners to whom they have granted privileges. Even now, in most cases where a patient sues a physician for negligence, the hospital in which the patient was treated is also named as a defendant.

Hospitals were hard hit by the insurance crisis. In 1985-86, hospitals faced a 362 per cent increase in the basic cost of liability insurance, and the percentage of the total provincial hospital operating budget spent on liability insurance premiums increased from 0.093 per cent or $3.5 million in 1983-84, to an estimated 0.493 per cent or $20.5 million in 1985-86. The availability of liability insurance became severely limited, with only two major insurers continuing to offer hospital liability insurance.

The Ontario Hospital Association responded to this situation by establishing the Hospital Insurance Reciprocal of Ontario (HIRO). The Reciprocal, which went into effect on July 1, 1987, is an unincorporated pool of hospitals contracting with each other to share risks and losses. It is a type of self-insurance program. The Reciprocal will provide coverage for each participating hospital to a limit of $5 million per occurrence. For hospitals wishing to purchase additional insurance above this level, the Reciprocal will try to obtain coverage in the commercial market. Each hospital is individually assessed a premium.

Physicians

Physicians are not required by law to carry insurance, but almost all do. Hospitals require physicians to carry an acceptable amount of insurance or to belong to the Canadian Medical Protective Association (CMPA) as a condition of granting privileges to them.

Nearly 90 per cent of Canadian physicians belong to the CMPA, which is another kind of self-insurance program rather than an insurance company. A physician pays an annual CMPA membership fee, which varies with the nature of the specialty or field of practice and reflects the cost of past and anticipated claims. The CMPA provides legal services to its members and pays the court awards, settlements, and legal costs assessed against them. According to a research paper prepared for the Task Force on Insurance, the existence of the CMPA has contributed to markedly lower medical malpractice insurance costs in Canada than in the United States.

For 1987, the CMPA membership fee for specialists practising obstetrics is $8,250. The fee is $1,675 for general practitioners practising obstetrics (which is understood to mean the conduct of labour and delivery), and $800 for general practitioners not practising obstetrics. (In comparison, an obstetrician practising in the New York State may pay a malpractice insurance premium of $80,000 a year.) The $8,250 charged obstetricians is the highest CMPA fee (charged also to cardiovascular surgeons, neurosurgeons, and orthopaedic surgeons). The 1987 fee is considerably higher than the $4,900 paid by obstetricians in 1986 and the $1,950 paid in 1984, the first year CMPA fees varied with the field of practice. Fees paid by general practitioners practising obstetrics have also increased, although not as sharply. In June, 1987, the provincial government agreed to provide funding to reimburse physicians in full for the 1987 premium increases.

The number of Canadian physicians involved in litigation increased from 516 in 1982 to over 1,500 in 1985, and the amount paid out by the CMPA rose from $5.96 million in 1982 to $13.78 million in 1984. We were told by the CMPA that litigation costs have increased over the past six or seven years for all groups of physicians, and that the major reason for this is changes in the way courts assess damages, not changes in the way physicians practise medicine.

Nurses

Malpractice insurance is available to nurses through the Registered Nurses Association of Ontario and the Ontario Nurses Association. Insurance is not mandatory for nurses, and many are satisfied with the insurance protection provided by their employers, and do not purchase individual protection. Until this year, the carrier of both the RNAO and ONA insurance policies was a group of four commercial insurance companies. In 1986 ONA was confronted with less attractive coverage and a large premium increase, which it felt was unjustified in view of its members' risk experience. In response, ONA decided to establish a self-financed program. All ONA members pay an annual "premium", which is included in their dues and allocated to the insurance program. If the costs incurred by the program exceed the accumulated premiums and the investment income earned by them, members will be levied a special assessment. The premium for 1987 is $12 per nurse per year and the insurance limits are $1.5 million per occurrence and $6 million annual aggregate. ONA insurance is available only to nurses in ONA bargaining units, and it is compulsory for them.

All members of RNAO — except those working for employment agencies, at industrial sites, or in private practice — may purchase insurance through the association. Among the policy's exclusions are claims resulting from the provision of midwifery services; midwifery is defined as "the management of care of newborns and women, antepartally, intrapartally, postpartally and/or gynaecologically, occurring outside of a hospital." The RNAO policy is carried by a group of four insurance companies. The premium is $14.70 per nurse per year and the policy limits are $3 million per loss and $6 million annual aggregate for all nurses.

The policy is a "claims made" policy, covering nurses for claims made during the life of the policy in respect of services provided after November 1, 1985. This is generally considered to be inferior to an "occurrence" policy, which provides coverage for all services rendered during the life of the policy, regardless of when the claim is made.

Both ONA and RNAO also offer their members legal assistance plans which provide legal advice and representation in employment-related matters up to specified limits. Legal representation in malpractice matters is provided through their liability insurance programs.

Nurses not eligible for RNAO or ONA insurance may purchase individual insurance. We were informed of sample premiums of $500 for a nurse in part-time private practice providing foot care and $2,500 for a full-time self-employed private duty nurse practising in patients' homes.

The insurance provided to nurses by the RNAO and ONA programs is much less expensive than medical malpractice insurance. This is partly because the insurers assume that nurses are covered by their employers' insurance policies and that their own insurance is "excess" coverage, primarily designed to protect nurses in the event of a shortfall in the employers' coverage. It also results from nursing's more limited scope of practice.

Midwives

Midwives currently practising in Ontario have no liability insurance coverage. Insurance is unavailable to them because insurers will not insure what they regard as illegal acts. As far as we are aware, no midwife in Ontario has been the subject of a malpractice action. The midwives believe that their style of practice, which emphasizes full and open communication with clients and the use of informed choice agreements, minimizes the risk of lawsuits.

Midwives' Experience in Other Jurisdictions

The professional malpractice insurance crisis is largely restricted to North America. None of the midwives we met in Denmark, The Netherlands or the U.K. reported that insurance posed a problem for them, and it is our impression that very few carry insurance.

The situation is quite different in the United States. As we outlined in Chapter 2, Certified Nurse-Midwives have recently weathered an insurance crisis. Insurance became very difficult to obtain and very expensive. A consortium of insurers was eventually formed to underwrite professional liability insurance for American College of Nurse-Midwives members. The coverage provided will be on a claims made basis and the annual premium will be approximately $3,500 for coverage of $1 million per occurrence and $1 million annual aggregate per CNM. In addition, the ACNM is establishing a mutual insurance company, which will likely offer coverage of $250,000 per occurrence and $250,000 annual aggregate per CNM for an annual premium of $3,000. To establish the mutual insurance company, each practising CNM will be required to pay $1,000 into a special account. When the account reaches $750,000 the company will be incorporated (Kendellen, 1987).

Some CNMs have not purchased individual insurance, relying instead on their employers' insurance policies. Others hope to shelter under insurance policies available to nurses. In a few states, government agencies provide reasonably priced insurance. In New Jersey, the insurance company that insures the majority of physicians also covers CNMs. The premium is $2,000 for CNMs conducting deliveries and $500 for those who are not; the coverage is limited to $1 million per occurrence with an annual aggregate of $3 million. The company agreed to insure midwives because of their good record, because their patients are "normal", and because all complicated patients are referred to obstetricians. (The company also insured two birthing centres in the state after reviewing such things as the consent forms signed by patients, the rapport established between CNMs and their clients, the emergency equipment on the premises, the proximity of the nearest hospital, the response times of the rescue squads, and the protocols for consultation and management of patients with complications.)

We were informed by the ACNM that about six per cent of CNMs have been sued. According to a recent article in the *American Journal of Nurse-Midwives* (Kendellen, 1987), the average claim paid by CNMs during the last 10 years was $70,000 U.S., and there have been payments as high as $500,000 U.S. These payments are much lower than those paid by physicians, primarily because CNMs care for low risk women and refer complicated cases to obstetricians, and because they usually do not have and are not seen as having primary liability. The premiums are nevertheless expensive for CNMs, whose incomes average about $30,000 U.S. a year. It has been suggested that the ultimate consequence of the unavailability of affordable insurance will be that CNMs will give up private practice and practise exclusively in institutions.

Causes and Characteristics of the Insurance Crisis for Canadian Health Professionals

A background paper on professional liability insurance prepared for the Task Force on Insurance by W. Donald Lilly, Q.C., identified several factors as contributing to the insurance crisis for professionals. The most important factors have nothing to do with how the professions are practised or the quality of professional services. Canadian insurance companies lack the capacity to provide liability insurance for all professionals across Canada. This would require them to bear a premium capacity of over $100 million. Many companies that formerly offered professional malpractice insurance no longer do so, further straining the capacity of the insurers remaining in the field.

One of the main reasons they have stopped is that reinsurance is virtually unattainable. Through reinsurance, a company shares its risk with another insurer, paying it a portion of the premium received from the insured. Most reinsurance comes from Lloyds of London, which withdrew from the North American professional liability reinsurance field because of bad experiences in the U.S. Lilly concluded, "Professionals relying on the traditional insurance market must get used to lower limits, higher deductibles and, for a certain percentage of the professions, no insurance at all." (Lilly, 1986, p. 2)

Lilly identified various features of the Canadian legal system that cause "unfair risk exposure" for professionals. Some of these features are particularly relevant to health professionals, including midwives.

One problem is the doctrine of joint and several liability, whereby every member of a group that collectively contributes to the damage to an injured person is liable for 100 per cent of the damage. If one member of the group cannot pay his or her share, the other members must make it up. Conceivably, if one person is held to be only one per cent liable, but all the other people at fault have no insurance and cannot pay their share, that person will be forced to pay 100 per cent of the damages. According to Lilly, joint and several liability increases everyone's potential payout and encourages plaintiffs to sue every potential party, resulting in escalating legal costs. Joint and several liability is one reason physicians insist that the midwives with whom they will be associating must be insured and that the CMPA advises physicians to ensure that other health professionals with whom they practise carry adequate insurance.

A second problem is uncertainty concerning the commencement date of the limitation period for making claims against professionals. The *Health Disciplines Act* requires that an action arising out of negligence or malpractice in respect of professional services rendered by a member of a college (that is, a dentist, physician, nurse, optometrist, or pharmacist) be commenced within one year from the date when the claimant knew or ought to have known the facts upon which the negligence or malpractice is alleged. This creates the possibility of actions being brought long after the services are provided. In contrast, the limitation period for actions against hospitals and their employees (including nurses) is two years from the date the claimant is discharged from hospital or ceases to receive treatment at the hospital. Lilly recommended that the limitation period for all professionals have a clear-cut, easily identifiable commencement date, preferably the date of the last professional service rendered.

The *Health Insurance Act* requires an injured person to include a claim on behalf of OHIP for past and future medical expenses in any malpractice action. Thus the insurer must pay the medical expenses caused by the malpractice or negligence of the insured. These expenses can be very large. Lilly recommended that OHIP's "subrogation right", as it is termed, be abolished on the principle that health care is a state activity and that its costs should not be recoverable by either an individual or the state.

The ways that court awards are calculated cause problems for professionals. Ontario courts require a "gross-up" of lump sum awards to cover the tax that will be payable on the income earned. The gross-up is regularly allowed, both with respect to the cost of future care and to the prospective loss of earnings. It results in a significant increase in the amount that must be paid out by the insurer. The gross-up is avoided if a periodic payment rather than a lump sum is awarded by the court. However, a schedule of periodic payments requires the consent of all affected parties, and consent is sometimes withheld or unobtainable. Lilly recommended that the courts be empowered to award a structured settlement without consent if it is in the best interests of all the parties.

Currently, a damage award is not reduced by the amount of outside benefits paid the injured person. Lilly felt that claimants should not take advantage of duplicate payments from disability insurance and public social security programs. Insurance costs would be reduced if these payments were subtracted from the amount to be paid out by the insurer. Lilly also recommended that the discount rate, which is applied to damage awards by courts to make up the difference between the anticipated investment interest rate and the rate of inflation, be reviewed to ensure that it is appropriate.

Lilly reported that more than 50 per cent of medical malpractice claims concluded each year by the CMPA result in no payment to the claimant. He commented:

> It is clear that many of these were without legal merit, something which should have been recognized by the plaintiff relatively early in the course of the lawsuit. It appears that a significant number of these cases are prolonged unnecessarily because the plaintiff insists on continuing at no financial cost to himself, and legal aid authorities authorize this continuance. When ultimately the plaintiff discontinues an action which has no legal merit, it is futile to attempt collection of costs because the plaintiff is impecunious.

He recommended that Legal Aid should be responsible for court costs awarded against unsuccessful claimants and that the courts be empowered to require claimants residing in Ontario to put up security for costs in appropriate cases, such as when it appears the claim may be frivolous.

Finally, with respect to hospital liability, Lilly recommended a review of the issue of whether hospitals should be held corporately responsible for the actions of independent physicians; he also recommended that input be obtained from all who may be affected by the resolution of this issue.

The causes of and solutions to the insurance crisis as it affects midwives go far beyond the mandate of this Task Force. While there may be factors peculiar to midwifery that will bear on the ability of midwives to obtain affordable liability insurance, these factors are less significant than the overall characteristics of the insurance system. The recommendations made by the Task Force on Insurance (which were not identical to those proposed in the Lilly paper) are currently being reviewed and debated. Clearly, anything that improves the general insurance climate will likely benefit midwives. Later in this section we suggest specific actions that may be open to midwives.

Should Insurance be Mandatory?

Whether liability insurance should be mandatory for midwives was a matter of concern to some professional organizations and health care providers who made submissions to the Task Force. However, the focus of many of the comments was whether insurance would be available at a price midwives can afford. The College of Physicians and Surgeons of Ontario and the Ontario Medical Association generally felt that midwives should be covered by adequate liability insurance. Self-employed midwives would have to obtain malpractice insurance individually. Several physicians said that insurance was necessary to protect the public; some also expressed the view that physicians should not be responsible for insurance coverage for midwives. The CMPA told us that it would advise a physician to be sure that any midwife with whom he or she intends to have a practice relationship carries adequate liability insurance. If she does not, the CMPA may deny coverage to the physician should he or she become liable for damages attributable to the midwife's negligence. This advice is now given to physicians practising with other caregivers.

Nursing groups appeared to somewhat less concerned about insurance than medical bodies. Only the submission of the Registered Nurses' Association of Ontario specifically addressed the insurance issue, focussing on availability. Some individual nurses who made submissions to the Task Force, including those who identified themselves as nurse-midwives, expressed concern about the insurance issue and recommended that the profession be structured in such a way that Ontario midwives do not have the problems of U.S. midwives in obtaining liability insurance.

The Ontario Hospital Association and individual hospitals said that midwives employed by hospitals would be covered by the hospitals' insurance policies. Some concern was expressed about the impact this might have on the hospitals' insurance costs. It is our impression, however, that hospitals do not predict large premium increases as a result of employment of midwives. The risk of increased premiums was not identified as an obstacle by several hospitals that made proposals to establish midwifery services. However, some hospitals, as well as the OHA, predicted that because of the risk of increased liability, midwives employed by hospitals would be limited in the functions they are permitted to perform off hospital premises. In particular, attendance at home births might be perceived as presenting an unacceptable risk.

The Task Force's review of the scientific literature on home birth (set out later in this chapter) suggests that it may be erroneous to assume that hospitals' liability costs will inevitably increase if midwives attend at home births. Nevertheless, we recognize that insurance companies may believe this to be true and that the Hospital Insurance Reciprocal of Ontario may be reluctant to cover hospitals for the risk incurred by midwives who attend at home births. At the same time, we believe it is important for midwives employed in hospitals to be able to attend at the home births of carefully screened clients to whom they have provided pregnancy care. If hospital midwives cannot do so, women desiring home births will be unable to use their services, and may choose to be cared for by unskilled persons if no other midwives are available.

The solution to the liability problem may lie in passing on to home birth clients part or all of the extra insurance costs that the hospital incurs as a result of providing the home birth service. The hospital would obtain excess insurance to cover its home birth liability and charge each home birth client a share of the insurance cost. HIRO may be prepared to provide coverage at a higher cost than coverage that excludes home birth. We recognize that the share of the cost charged to each client might be substantial. Nevertheless, we feel this is a fair way of financing a costly service desired by a small number of clients.

Midwifery organizations also focussed their attention on the availability of affordable insurance. They sought to explain why midwives are less likely than physicians to be sued. The Association of Ontario Midwives described at length how the nature of midwifery practice deters malpractice claims. It described a model of care called "defensible practice", which emphasizes communication skills and rapport between client and practitioner. According to the AOM, "sharing of uncertainties" is an important factor in deterring malpractice suits. This means that there should be an understanding between practitioner and client that even the best of care does not eliminate all of the risks of childbirth. There can be no absolute assurance of a perfect obstetrical outcome.

Defensible practice requires that a caregiver be aware of current standards and current literature. The practitioner's course of action must be defensible, given current practice and research. The midwife must provide the pregnant woman with information regarding the known risks and benefits of procedures, so that she can make an informed choice. The midwife must be accountable for her actions through communication and documentation of treatment, and she must be open to feedback about the care she is providing. The AOM argues that widespread adoption and integration of informed choice agreements could be instrumental in solving the malpractice problem. Informed choice requires that the client receive an understandable explanation of the proposed treatment or procedure, its necessity, risks and potential benefits, and the feasibility of alternatives.

The AOM acknowledged that although midwives are rarely sued, obstetrical malpractice suits result in very large payments. The current small population of midwives could not support even one such payment. There are not enough midwives or funds available to establish a protective association like the CMPA to provide immediate coverage, and insurance companies may be unwilling to insure a new type of caregiver. The AOM said that appropriate mechanisms should be developed to provide midwives with malpractice insurance. It did not explicitly say whether or not midwives should be permitted to practise without insurance.

The Task Force believes that whether midwives should be legally required to carry liability insurance is an issue separate from the question of availability and cost. It is impossible to predict whether it will be possible for midwives to obtain reasonably affordable insurance. For one thing, the very fact that insurance is or is not made mandatory may affect its availability and cost, both by influencing the number of midwives among whom the risk can be spread and by creating a captive market. We lack the information and the expertise to predict what the liability insurance climate will be like when midwifery is integrated into the health care system.

The Task Force recommends that liability insurance be mandatory for practising midwives.

The minimum amount of insurance that is required should be determined by the governing body. For midwives employed by hospitals and other health care facilities, it may be sufficient for them to demonstrate that their employers are insured. Midwives in private practice would be required to obtain individual insurance.

Our recommendation is based on four considerations. First, in the model of midwifery we are recommending, the midwife will be a primary caregiver. She will practise autonomously within her scope of practice, and while she will collaborate with physicians, she will not be supervised by them. She will exercise independent clinical judgment in the management of pregnancy, labour and birth, and postpartum care. She will be primarily responsible if something goes wrong. Accountability is concomitant with responsibility, and for a midwife to be truly accountable for her actions, she must carry liability insurance.

Second, for midwifery care to be safe and effective, there must be open communication between midwives and physicians. Midwives must be able to consult with and refer to physicians freely. At the same time, physicians must respect the midwife's right to manage care until responsibility is transferred to them. Various individual physicians and medical bodies have expressed concern about the likelihood of midwives obtaining liability insurance. We think that unless midwives are insured, some physicians will not feel free to consult with them or accept referrals from them, for fear that their own liability will be increased. Alternatively, some physicians may insist that management of care be assigned to them. Neither eventuality is satisfactory.

Third, we think that midwives must be insured if they are to be a genuine option for women. We doubt that many women think about insurance when selecting a caregiver; nevertheless, insurance coverage would be a reasonable factor for a woman to consider in deciding whether or not to obtain care from a midwife. Her choice should not be between an insured physician and an uninsured midwife.

Fourth, we think that without liability insurance, midwives' practice options may be unduly limited. Physicians may be unwilling to work with uninsured midwives in co-practice arrangements. Hospitals, which require the physicians who practise in them to have insurance, are unlikely to grant privileges to uninsured midwives.

We do not disagree with the AOM's statement that defensible practice and informed choice agreements deter malpractice claims. The fact remains that they cannot prevent them absolutely. Nor are midwives completely protected by the fact that they care for women with uncomplicated pregnancies, and refer to or consult with physicians when their clients develop complications. Any client for whom the outcome is bad is a potential claimant, if only because the midwife should have referred her to a specialist earlier. The more midwives there are, and the larger the number of midwifery clients, the greater the likelihood of a claim being made against a midwife. Successful claimants are surely entitled to have their damages paid. If the claim is without merit, the midwife still needs to be represented by a lawyer until the case is brought to a conclusion. Few midwives can afford legal defence fees or a damages award without insurance coverage.

We have considered whether it is unfair to require midwives to be insured when insurance is not mandatory for physicians and nurses. Virtually all practising physicians do have insurance through the CMPA, and hospitals insist that physicians with privileges be insured. The majority of nurses practise in institutional settings where they are covered by their employers' insurance and many nurses also carry their own insurance through RNAO or ONA. As well, nursing practice carries fewer risks than midwifery practice. Nurses (with the exception of some who work for Health and Welfare Canada in outpost settings and nurses in the Chedoke-McMaster Nurse-Midwifery Project) are not responsible for the management of care of pregnant women, and they do not conduct deliveries on their own responsibility. Where nurses find themselves in positions of primary responsibility (for example, self-employed private duty nurses), they seek insurance.

We have also considered whether making insurance mandatory for midwives will mean that the insurance industry ultimately determines which practice settings are open to them. Obtaining insurance will probably be most difficult for self-employed midwives. It is possible that they will be driven from private practice if no insurance is available, or if its cost is prohibitive. While this would not be desirable, neither, in our view, would be practice without insurance. It would expose the midwife's clients to excessive risk, and would make it too difficult to secure crucial links with physicians and hospitals. In our view, if midwives are restricted to institutional practice, as it has been predicted may happen in the U.S., then the development of midwifery will have been needlessly thwarted. If this appears likely to happen in Ontario, it will be necessary for the government to consider taking extraordinary action to assist midwives to obtain insurance.

Availability of Insurance

It is unclear whether affordable insurance will be available to midwives. The Task Force consulted with two major international insurance brokers carrying on business in Canada. We made no attempt to obtain a commitment or a quotation from an insurer. Obviously no commitment could be obtained before decisions are made about the implementation of midwifery. Furthermore, the insurance climate is changeable, and conditions may be different when midwives actually try to obtain coverage.

We were informed by officials at Reed Stenhouse Limited that the insurance climate has improved and that conditions in early 1987 make it somewhat more likely that insurance will be obtainable. We were told that insurers will be concerned about such things as midwives' education, their relationships with physicians, and their places of practice. Attendance at home births may be particularly troublesome. Another problem will be the small size of the profession, because there will be fewer practitioners amongst whom to spread the risk, especially if midwives who are employees do not obtain their own insurance. It would therefore be helpful for all Canadian midwives to obtain insurance from the same source (assuming midwifery is legalized in other provinces). We were also told that it might be helpful for midwives to be insured through their governing body, which could provide assurance to the carrier that only duly registered midwives obtain coverage. The premium cost will be lower if there is a deductible, and it was suggested that a self-insurance program might be organized to cover the deductible.

We also consulted with Marsh and McClennan Group Associates Limited, which serves as insurance broker for RNAO and several other health professions. Marsh and McClennan were unable to obtain underwriters' reactions to midwives' potential insurability because of the uncertainty as to how midwifery will be implemented. On the basis of the experience of CNMs in the U.S., the broker thought insurance for Ontario midwives could be very expensive.

However, in our view, the experience of CNMs is more encouraging than daunting. They have weathered the insurance crisis, at least for the time being, by being innovative and aggressive. We are sure that Ontario midwives can be equally so.

There are obvious advantages to establishing a self-financed program. As was noted, both the Ontario Hospital Association and the Ontario Nurses Association have recently developed self-insurance programs for their members.

The Task Force recommends that midwives, through their professional association, take steps to develop a self-financed insurance program as soon as possible.

Initially, the program might be used to cover midwives for the deductible portion of any insurance policy obtained in the commercial market. Eventually it might provide comprehensive liability insurance.

Birth at Home

Throughout this chapter we have emphasized the importance of midwives working in both community and hospital settings. We have stressed that community based midwives must have access to hospital birthing facilities, and that hospital based midwives must be permitted to provide care in out-of-hospital settings, including clients' homes. The aspect of this likely to provoke the greatest controversy is the principle that midwives should be permitted to attend home births.

Attitudes Toward Home Birth

The Canadian medical and nursing professions — their governing bodies and professional associations — are virtually united in their opposition to planned home birth. One notable exception is the Medical Reform Group of Ontario, which has criticized the scientific basis upon which the College of Physicians and Surgeons opposes planned home birth. This opposition is founded on their belief that home birth is demonstrably less safe than hospital birth for mothers and newborns. They believe that parents who choose home birth are misguided or poorly informed and that professionals should try to dissuade parents from home birth.

The Association of Ontario Midwives and its sister organizations across Canada have a different view of home birth. These organizations believe that both home and hospital carry risks and that home is a safe birthing environment for properly selected women. They believe it is the midwife's role to assess the risks of home birth in each individual case and to explain these risks fully to the parents so that they can make an informed choice. It is then the midwife's responsibility to support the parents' decision as far as possible.

The small number of home births each year in Ontario (shown in Table 1) may not accurately reflect the public's attitude to home birth. In a public opinion survey conducted in Ontario by Environics Research Group in August 1986, 43 per cent of the respondents said they felt delivery of babies by midwives should take place in either home, hospital, or birth clinic; only 26 per cent believed deliveries should be confined to hospitals.

Table 1: Live Births and Births Out of Hospital: 1980-1985

Year	Live Births	Births Out of Hospital	
		Number	Percentage
1980	123,316	541	0.4
1981	122,183	560	0.5
1982	124,856	554	0.5
1983	126,826	486	0.4
1984	131,296	487	0.4
1985	132,208	488	0.4

Source: Registrar General of Ontario

The number of home births reported includes both planned and unplanned home births. The number of planned home births might decrease if hospitals provide more congenial environments for childbirth, when birthing centres are established, and if midwives can care for their clients in hospitals and birthing centres. Conversely, the number might increase if midwives and physicians become more widely available to attend home births. What seems certain is that some women will always choose to give birth at home and that planned home birth will never be eliminated.

The Issue of Safety

While the Canadian nursing and medical professions oppose home birth on the basis that it presents inordinate risks for all women and newborns, some supporters of home birth claim that it is safer than hospital birth for some women and babies. Recent reviews of the scientific literature have concluded that the evidence to support either claim is inconclusive (Campbell and Macfarlane, 1986; Alberman, 1984).

One of the major reasons for this inconclusiveness is the methodological problems inherent in investigating the relative safety of home and hospital. In the past, the issue was investigated by comparing maternal mortality rates. Since maternal deaths have become rare events, the perinatal mortality rate (the number of stillbirths plus the number of deaths in the first week after birth per 1000 total births) is now the favoured measure of the outcome of pregnancy. One might expect that comparisons of perinatal mortality rates associated with home and hospital births would be revealing. In fact, they are often misleading because statistics on home birth include unplanned home births (which often occur precipitously and to women who have received no pregnancy care), mothers who cannot afford hospital, or adequate care, women who insist on giving birth at home against medical advice, and babies born with lethal congenital malformations.

Isolating place of birth from other factors was recognized as hazardous by the British Medical Association as early as 1936:

> Maternity and its conduct are not concerned merely with attendance during the actual process of delivery, but comprise supervision from first to last — from the time that changes consequent upon conception manifest themselves until their return to normal some short time after childbirth. It is obvious that this whole period and event cannot be isolated from the rest of the health history of the mother, whether before, during or after the period of actual pregnancy and parturition. (Quoted in Campbell and Macfarlane, 1987)

Comparisons of home and hospital outcomes tend to ignore the fact that the care and services provided by different hospitals vary greatly, just as services available for home births vary. Furthermore, international comparisons may be invalid unless they take account of differences in the ways maternity services are organized and in the ways statistics are collected and interpreted.

The decreases in perinatal mortality rates that have occurred in developed countries during the 20th century are often attributed to increases in the proportion of births taking place in hospitals. In fact, several British studies suggest that the relationship between the two phenomena is probably coincidental, not causal (Campbell and Macfarlane, 1986; Chalmers et al., 1976; Barron et al., 1977; Fryer and Ashford, 1972). Nor is the opposite claim, that the perinatal mortality rate would have shown an even greater fall if the proportion of hospital births had not increased as much (Tew, 1986), supported by anything other than statistical association (Campbell and Macfarlane, 1987). And while a number of British studies have found substantially lower perinatal mortality rates among home births, (Butler and Bonham, 1963; Richards et al., 1970; Chamberlain et al., 1975), they have been criticized for failing to take full account of "the complex biological, social and medical selection process which influenced the choice of place of birth." (Campbell and Macfarlane, 1986, p. 677)

Furthermore, analyses based on *actual* place of birth sometimes fail to recognize that some women may not give birth where they had intended. A British study of all home births occurring in 1979 found that only two-thirds were planned home births; the perinatal mortality rate for these planned home births was 4.1 per thousand. The rate for births that took place at home but which had been planned to occur in consultant units (that is, units where care is provided by obstetricians) was 67.5 (Campbell et al., 1984). There is evidence that with the decline in the overall numbers of home births, an increasing proportion are unplanned, and that this tends to skew the perinatal mortality rate upward (Tew 1981; Campbell et al., 1982; Murphy et al., 1984). Studies that have classified births according to place booked for delivery rather than actual place of birth (Fedrick and Butler, 1978; Cookson, 1963; Hobbs and Atcheson, 1966, Wood, 1981) have not found statistically significant differences between mortality rates for births booked for hospital, home, and general practice maternity units (where care is provided by general practitioners and midwives) (Campbell and Macfarlane 1987; Tew, 1978).

There is much evidence that transfer of the woman to hospital, particularly while she is in labour, is associated with a high perinatal death rate (Butler and Bonham, 1963; Hudson, 1968; Woodall, 1986; Rutter, 1964; Rees, 1961). Different investigators have interpreted this evidence as proving the unsafety of home or hospital. Marjorie Tew, a British statistician well known for her work demonstrating the apparent superiority of home birth, asserts that the perinatal mortality rate for babies born to transferred women is twice as high as it should be and that this is the result of increased obstetric intervention after they are transferred to hospital. Campbell and Macfarlane, whose work is supported by the British National Perinatal Epidemiology Unit, point out that Tew's assertion ignores the possibility that the delay in intervening when a women is transferred from home increases the risk of death.

The lack of a causal relationship between place of birth and perinatal mortality in The Netherlands was demonstrated in a study of perinatal mortality rates in regions with differing proportions of hospital births (Treffers and Laan, 1986). The authors of the study conclude that hospitalization is not a major factor in determining the perinatal mortality rate. However, they warn that the finding, while true for The Netherlands, may not be valid in countries with different systems of care.

As perinatal mortality rates have declined, increasing attention has been focussed on maternal and infant morbidity (that is, disease associated with the process of birth). Several studies have compared the morbidity outcomes of home and hospital births.

For example, a study based on the 1970 British Birth Surveys compared babies born in different settings who were described as unfit. Babies born at home suffered more from jaundice and minor infections than those born in hospital, but babies born in hospital had a larger percentage of more serious conditions, such as congenital malfunctions, fits, cerebral signs, and respiratory difficulties (Chamberlain et al., 1975). Another study found that children born at home and in GP units in Northern England between 1960 and 1975 had lower cerebral palsy rates than children born in consultant units where care is managed by obstetricians (Jarvis et al., 1985). Similarly, a Dutch study of 1,692 low risk women found that women who gave birth at home suffered fewer complications during pregnancy, labour, and birth than those who gave birth in hospital and that in babies born without complications, morbidity leading to referral to a special care unit was lower among those born at home and higher in those born in hospital (Damstra-Wijmenga, 1984). However, in none of these studies were attempts made to control for selection biases (the factors that influence choice), so that it is impossible to assess the extent to which the differences in morbidity can be attributed to differences in place of birth (Campbell and Macfarlane, 1986).

Other investigators have focussed on rates of obstetrical intervention as well as mortality and morbidity. In an often cited U.S. study, Mehl (1978) compared 1,046 hospital and home births of women matched for obstetrical history, age, socioeconomic status, and obstetric risk factors. Table 2 demonstrates some of his findings:

Table 2: Rate of Obstetrical Interventions for Planned Home and Hospital Births, Mehl, 1978.

	Home		Hospital	
	No.	%	No.	%
Prepartum use of Oxytocin	76	7.3	173	16.5
Mid forceps	10	0.9	205	19.6
Low forceps	3	0.3	115	11.0
Caesarean section	28	2.7	86	8.2
Episiotomy	103	9.8	914	87.4
General anaesthesia	2	0.2	96	9.2
Analgesia	14	1.3	555	53.1

(Note: Forceps, Caesarean section, anaesthesia, and analgesia were used on 113 women transferred from home to hospital.)

While Mehl's study revealed no significant differences in mortality or neurological impairments, the differences in intervention rates were striking. The rate of episiotomy was nine times higher in hospital and there was a statistically significant excess in the number of second, third, and fourth degree lacerations. A significantly greater proportion of babies born in hospital had birth injuries, infections, respiratory distress lasting longer than 12 hours, and non-congenital complications.

Significant increases in rates of Caesarean section, vacuum extraction and forceps deliveries occurred in Denmark during the period 1960 to 1980 when that country's proportion of institutional births increased from about 50 to 99 per cent (Scherjon, 1986). Perinatal mortality decreased during the same period, but not necessarily because of the increase in hospital births. The author concluded that Denmark had to pay for the better perinatal results with a high number of interventions, and that more hospitalization induces a higher chance of intervention.

However, this and similar studies showing higher intervention rates in hospital births do not prove that such rates are inevitable. A California study matching practitioners with similar attitudes to birth found intervention rates in home and hospital births to be similar (Mehl et al, 1980).

There is no simple conclusion to be drawn from the scientific literature about the extent to which place of birth influences outcome. A controlled randomized trial, in which women are randomly assigned to give birth at home or in hospital, would provide an unbiased assessment of the risks associated with different places of birth, but such a trial is impractical because it is unlikely that sufficient numbers of women would agree to be randomly assigned a place of birth. However, a review of the scientific literature by Campbell and Macfarlane published in the *British Journal of Obstetrics and Gynaecology* (1986) concluded that the available evidence suggests the following:

- The statistical association between the increase in the proportion of hospital births and the decline in the perinatal mortality rate is not wholly or even mainly explained by a cause and effect relationship. There is no evidence to support the claim that the safest policy is for all women to give birth in hospital.
- Morbidity does appear to be greater among women and babies delivered and cared for in hospital; however the evidence is not conclusive that the risks of hospital delivery are greater than the benefits.

A recent editorial in the *Canadian Physician* commented:

> In summary then, it seems that the imposition of almost universal hospital delivery has not brought all the benefits once thought likely to follow, and that while for some high-risk situations it has indeed been useful, it may have been so at an unforeseen price for many low-risk mothers. The shift to hospital confinement was a social movement that took place at a time when labour and delivery were life and death matters, rather than a scientific movement based on adequate data and well-tested hypotheses. It remains a social rather than a scientific issue, with polarised views expressed in rhetoric rather than reason. (Dixon, 1987)

The Task Force realizes that this discussion of the inconclusiveness of the scientific literature is unlikely to alter the opinions of those who are committed to the belief that one or other place of birth is demonstrably superior. However, we think there can be a consensus that all places of birth should be made as safe as it is possible to make them with the scientific knowledge and resources available. Much attention is, of course, directed toward making hospital maternity services as safe and effective as possible. We believe attention should also be directed toward maximizing the safety of home birth, recognizing that regardless of the prevailing opinion among health professionals, it will continue. It is important to recognize that efforts can be made in this direction without the expenditure of vast sums of money.

Home birth is made safer if only carefully selected women give birth at home. This means that midwives and physicians must be highly competent in assessing the risks for each woman and baby. The risk assessment must include not only physical and physiological factors but also the accessibility (in terms of distance, weather, traffic, and transport facilities) of hospital in the event of an emergency. Every midwife in The Netherlands is well schooled in a universally accepted list of contraindications to home birth. Among other things, the list serves to minimize, if not eradicate, differences of opinion among practitioners.

The Task Force recommends that the governing body for midwifery prepare a home birth protocol covering assessment of risk and contraindications to home birth. In preparing the protocol, the governing body should consult with appropriate professional organizations and authorities.

Women for whom home birth is clearly inappropriate because of their risk status will be less likely to insist on it if the factors that deter them from institutional birth are removed. Women who wish to be cared for by midwives should be able to do so in hospital. Hospital protocols and procedures should accommodate women's preferences in labour and birth — including who accompanies them — and should eliminate unnecessary interventions and indignities. Enemas and shaves should be as rare in hospitals as they are in homes. Special care should be taken to put at ease women who face the hospital experience with trepidation because of language and cultural differences, past birthing difficulties, or particular socio-economic problems. Continuity of care should be maximized. Hospital staff should treat women with courtesy and sensitivity, and should keep them fully informed of the reasons for all procedures relating both to themselves and to their babies.

Despite expert risk assessment and improvements in the institutional birth environment, it is possible that some high risk women will choose home birth against all advice. This creates a dilemma for practitioners: is it their responsibility to attend the woman at home anyway, and to make the birth as safe as can be, or should they withdraw their services, in order to avoid appearing to sanction the unwise decision? The College of Physicians and Surgeons of Ontario advised its members in its Position Statement on Home Birth:

> To the extent that it is possible within the requirements of good care, some physicians may wish to consider the wishes of the patient regarding the delivery. A physician should not, however, be expected to compromise his position, or to accept conditions which would make it impossible to maintain the standards of practice of the profession. (CPSO, 1983)

This advice was reiterated in a statement issued in May, 1987 (CPSO, 1987).

In the U.K., midwives (but not physicians) are required to provide care to women who inappropriately choose home birth, and procedures exist for such cases to be reported to midwifery supervisors (UKCC, 1986). Interestingly, such cases do not appear to arise in The Netherlands, where home birth has never been romanticized as a "forbidden fruit"; there women accept advice to enter hospital when necessary (Kloosterman, 1984).

The Task Force recommends that the governing body for midwifery develop a standard of practice and establish a practice advisory service to provide guidance to midwives with regard to the care of women who choose to give birth at home despite contraindications.

There are several ways the process of home birth can be made safer for women who choose it. It is important that midwives who plan to attend at home births be qualified to do so. Attending at a home birth is not the same as attending at a hospital birth, where all necessary supplies, equipment, and backup services can be taken for granted. While it is probably not feasible to include home birth experience in basic midwifery education, it may be possible to arrange home birth electives for some. Electives in free-standing birthing centres in the U.S. would also provide useful experience.

Because it is impossible to screen out all women who will develop complications during labour and birth, advance arrangements must be made for transferring women to hospital. The woman should have her medical record with her at home. A contingency plan should exist for transport, whether by private vehicle or ambulance. There should be telephone communication with staff in the backup hospital if transfer becomes necessary so that they can be prepared to receive the woman and baby. The attitude among nurses and physicians in hospitals toward women transferred from home to hospital for birthing should be sympathetic and supportive, not punitive or judgmental. There must be arrangements for physicians to provide backup assistance — usually in hospital, but also at home when necessary; these arrangements are likely to be possible only if physicians are made to feel that providing backup is a matter of professional responsibility rather than a deviation from standards of good medical practice, and only if they do not incur inordinate legal liability in the event of a poor outcome.

In the U.K. specially trained and equipped medical teams called "flying squads" have been used to provide emergency backup to home births. Flying squads are not used in The Netherlands, but in that small country no one is very far from a hospital. Opinion as to the necessity and effectiveness of flying squads is divided. Some recent literature has suggested that they are neither cost-effective nor essential to ensuring the safety of home birth, and that limited use is being made of them (Ryan and Kidd, 1987). On the other hand, Dr. G. J. Kloosterman, a well- known Dutch home birth advocate, has stated that a functioning flying squad makes home birth possible for women living some distance from hospital because any woman can suddenly develop a dangerous complication; in his view it is particularly important that blood transfusions be close at hand (Kloosterman 1984).

Ambulance authorities for the Ministry of Health and Metropolitan Toronto told us that it is unrealistic to expect ambulance attendants and paramedics to function as flying squads for home birth emergencies. Because of their responsibility to respond to other emergencies, they cannot "stand by" home births, and even if they could, they could not be depended upon to resuscitate newborns. The cost of establishing a provincial flying squad network to cover home births would be high, especially in relation to the small number of home births.

The Task Force recommends that a flying squad network not be created in Ontario to support home births. We recommend that caregivers and parents take responsibility for ensuring that transportation will be available during labour if needed.

The Task Force doubts that it would be possible for midwives to maintain competence in the difficult technique of newborn intubation. Indeed, we were told that very few physicians outside children's hospitals can maintain this competence. However, the midwife's scope of practice includes activities related to emergencies, and all midwives would be trained in basic techniques of resuscitation. Midwives would carry to home births equipment and supplies for emergency measures, such as oxygen bag and mask and anti-haemorrhagic agents.

Appropriate arrangements must also be made for the postpartum period. Many Dutch experts say that their maternity aide system, which provides home supervision of postpartum women and newborns as well as housekeeping assistance, is an essential component of obstetric care and that home birth is safe in The Netherlands partly because of it. While the single visits to postpartum women required to be made by public health nurses in Ontario serve certain functions, we believe that they alone do not provide adequate supervision or support for women giving birth at home. It is even doubtful that they are sufficient for many woman who give birth in hospital. Most women, of course, make their own arrangements for postpartum assistance, employing private duty nurses or calling on their families and friends. But some do not have these resources. Caregivers — midwives, nurses and physicians — must see it as their responsibility to do what they can to ensure that women have adequate support during the postpartum period.

Finally, we believe there should be an evaluation of the safety of home birth in Ontario. Little Canadian research has been published on the safety or danger of home birth. As we have noted, it is dangerous to apply to Canada the research findings obtained in countries with different climatic, geographical, and social conditions. If careful records are kept of the morbidity and mortality associated with home births, as well as detailed information on the mother's risk status and whether the home birth was planned or unplanned, it may be possible at some point in the future to make a more objective assessment of the risks and benefits of home birth in Ontario. A firmer basis for policymaking might then exist.

The Task Force recommends that the Ministry of Health establish a home birth registry for the reporting of the mortality and morbidity outcomes of all home births taking place in the province. The registry should elicit detailed information on the mother's risk status, whether the home birth was planned or unplanned, and the causes of morbidity and mortality.

Recommendations in this Chapter

1. **The Task Force recommends that all midwifery practices display the following characteristics:**

   a) ***Continuity of care is provided.*** **Ideally, the midwife who cares for the woman during her pregnancy should be the one to attend her in labour and childbirth and to provide her postpartum care. This is possible only if the midwife's actual scope of practice encompasses every stage of the reproductive cycle, that is, if her job or practice includes pregnancy care, labour and childbirth care, and postpartum care. It may be more practical in some settings for a group of midwives to share a woman's care. They can provide a sufficient measure of continuity if the group is kept small, if caseloads are assigned carefully, if every midwife in the group shares a common philosophy of care, and if every midwife is aware of the woman's special needs and preferences.**

   b) ***The midwife's responsibilities include counselling, education, and emotional support.*** **Attention to women's psychological and social needs is an essential component of midwifery care. Women must also be well informed so they can make knowledgeable decisions about their care. Caseloads should be assigned and appointments scheduled so that a rapport can develop between midwife and client. The woman should have ample opportunity to ask questions, air her anxieties and express her preferences for childbirth. There should be time for her to develop confidence in the midwife or midwives who will be caring for her in labour and childbirth.**

   c) ***The midwife has access to both institutional and community settings.*** **Wherever her practice is based, the midwife should be able to provide care in a variety of locations. Midwives based in hospitals and birthing centres should be able to provide care in community settings, and midwives based in the community should be able to provide labour and childbirth care to their clients in hospitals.**

   d) ***The midwife has arrangements with physicians for consultation and referral and for ordering medications, tests, and procedures.*** **For midwifery care to be safe as well as effective, the midwife must be able to consult with general practitioners, obstetricians, and other medical specialists easily, and to make referrals to them readily. Physicians must be available within a very short time if complications develop during labour and childbirth. Practice protocols should set out the circumstances in which consultation and referral are required.**

   e) ***The midwife practises autonomously within her scope of practice.*** **Other caregivers must respect the midwife's autonomy. They must not interefere with her ability to manage pregnancy, labour and childbirth, and postpartum care.**

   f) ***The midwife focusses on low risk pregnancies and normal childbirth.*** **The midwife should specialize in the care of women with uncomplicated pregnancies, for whom a normal labour and birth are anticipated. In some cases, however, exceptions can be made to this principle, because of the attributes of midwifery care and the demand of the setting. For example, midwives can work effectively with physicians in caring for women whose pregnancies carry risks. It has been demonstrated that midwives provide effective care to very young and socially disadvantaged women.**

   g) ***The midwife has an opportunity to engage in continuing education and peer review.*** **These activities help the midwife maintain her competence. Arrangements with other midwives may be necessary to facilitate absences from the practice. The midwife should have access to other midwives and structured opportunities to review cases.**

   h) ***The midwife's working conditions are reasonable and she is fairly paid.*** **Continuity of care should not be at the expense of the midwife's private and family life, and the pace of work**

should not lead to rapid burn-out. This may require imaginative and flexibile scheduling of work and time off. The remuneration paid to midwives should fairly reflect their level of responsibility, the demands on their time, the difficulty of their work, and the cost of participating in continuing education activities.

i) *The practice is responsive to consumer needs and preferences.* Women who have used midwives described to the Task Force how their midwives adjusted to their needs and preferences, rather than the other way around. Responsiveness to consumer needs and preferences may be more easily achieved outside institutions. Within institutions, formal mechanisms should be developed to enable midwives to listen to their clients and adjust their services to meet their needs.

j) *The practice continuously evaluates its effectiveness.* Measures of effectiveness of midwifery care include intervention rates, morbidity (illness), mortality, and client satisfaction. Practices should have ongoing programs of quality assurance, and costs should be monitored. Institutional practices may have in-house resources to design and implement evaluation programs, while private practices may have to consult with outside researchers, such as those based in universities. The results of the evaluations should be widely disseminated as they will be valuable in making improvements to policy, education and practice.

k) *The care provided is cost-effective.* Each midwife should render an appropriate volume of service, and the number of hours of care allocated to each client should be neither inadequate nor excessive. Women should be discouraged from going to physicians (or other midwives) to obtain care that unnecessarily duplicates the care provided by their primary midwives.

2. The Task Force recommends that midwives work in hospital midwifery services that meet the requirements for safe and effective midwifery practice.

3. The Task Force recommends that midwives work in birthing centres that meet the requirements for safe and effective practice.

4. The Task Force recommends that the Ministry of Health expand the mandate of the Community Health Centre program to permit Community Health Centres to employ midwives, provided the requirements of safe and effective practice are met.

5. The Task Force recommends that midwives work in services sponsored by boards of health that meet the requirements for safe and effective midwifery practice.

6. The Task Force recommends that midwives work in private practices that meet the requirements for safe and effective midwifery practice.

7. The Task Force recommends that midwives and physicians work together in practices that meet the requirements for safe and effective midwifery practice.

8. The Task Force recommends that no midwife be permitted to practise except in a practice, service, agency or other health facility approved by the Ministry of Health.

9. The Task Force recommends that a mechanism be established in the Ministry of Health for approving all institutional and community-based midwifery practices and services. We recommend that proposals to establish such practices and services be evaluated by a designated operational branch in conjunction with the Women's Health Bureau of the Ministry, and that approval be granted to proposed practices and services that meet the requirements for safe and effective midwifery practice. We recommend that the Ministry be empowered to discontinue or cancel approval if a practice or service fails to provide safe and effective midwifery care after a reasonable opportunity has been provided for it to do so.

10. The Task Force recommends that the Ministry of Health appoint a member of its staff to assist applicants in preparing and submitting applications for program approval and funding.

11. The Task Force recommends that the Ministry of Health provide funding to approved institutional and community-based midwifery practices and services, including those proposed by individual midwives, groups of midwives, multi-disciplinary groups, boards of health, community agencies, physicians and hospitals. We recommend that funding be provided on the basis of global program-based budgets.

12. The Task Force recommends that midwives be prohibited from seeking or obtaining payment

for midwifery services directly or indirectly from clients.

13. **The Task Force recommends that midwives be permitted to charge fees for childbirth education classes.**

14. **The Task Force recommends that the Ministry of Health be empowered to permit organizations such as unions, voluntary associations, and charitable foundations to provide full or partial funding to approved midwifery practices and services.**

15. **The Task Force recommends that the *Public Hospitals Act* and Regulations be amended to empower hospitals to appoint midwives to the hospital staff.**

16. **The Task Force recommends that the *Public Hospitals Act* and the Regulations thereunder be amended to establish the necessary structures and procedures for appointing midwives to the staffs of hospitals.**

17. **The Task Force recommends that liability insurance be mandatory for practising midwives.**

18. **The Task Force recommends that midwives, through their professional association, take steps to develop a self-financed insurance program as soon as possible.**

19. **The Task Force recommends that the governing body for midwifery prepare a home birth protocol covering assessment of risk and contraindications to home birth. In preparing the protocol the governing body should consult with appropriate professional organizations and authorities.**

20. **The Task Force recommends that the governing body for midwifery develop a standard of practice and establish a practice advisory service to provide guidance to midwives with regard to the care of women who choose to give birth at home despite contraindications.**

21. **The Task Force recommends that a flying squad network not be created in Ontario to support home births. We recommend that caregivers and parents take responsibility for ensuring that transportation will be available during labour if needed.**

22. **The Task Force recommends that the Ministry of Health establish a home birth registry for the reporting of the mortality and morbidity outcomes of all home births taking place in the province. The registry should elicit detailed information on the mother's risk status, whether the home birth was planned or unplanned, and the causes of morbidity and mortality.**

Chapter 6

QUALIFICATIONS FOR PRACTICE

Purpose of the Chapter

The Government's decision to regulate the profession of midwifery raises the issue of qualifications for practice. This issue, of course, has a fundamental relation to the nature of the midwifery profession desired for Ontario. It has obvious implications for the midwifery educational programs to be established here. The discussion of qualifications for practice in this chapter includes consideration both of qualifications for entry to midwifery education programs and of the nature and content of those programs.

Models of Entry

The most basic question with respect to midwifery education is what qualifications a student must have before being permitted to embark on the study of midwifery. These "entry" requirements will inevitably affect the nature of the educational program and the sense of professional identity of the midwives emerging from the program. Because of the fundamental nature of the question of entry requirements, the Task Force had extensive discussions about it with the existing health care professions and canvassed extensively the views of consumers and the wider public. We have also scrutinized, through research and observation, entry requirements in other jurisdictions.

These inquiries indicate that given the nature of the health care system in Ontario, two alternative models merit consideration for adoption here. One model requires every person who wishes to study midwifery to obtain an education in nursing first. The other model permits a person to study midwifery without prior education in nursing; it is often referred to as "direct entry". However, we prefer to describe it as "multiple routes of entry" because the essential feature of this model is that it opens a midwifery career to people with a variety of educational backgrounds, including those with nursing education, those trained in other health disciplines such as physiotherapy, and those with no formal post-secondary education.

A crucial difference between these two models is that the first confers on the nursing profession a monopoly over midwifery: only nurses can train as midwives. The second model, multiple routes of entry, permits others to have access to the training, but does not exclude nurses. To a large extent, then, the choice between the two models involves deciding whether nursing should have a monopoly over midwifery.

The International Experience

The Task Force surveyed a large number of other countries to find out if the experience elsewhere could provide guidance to Ontario. We found it significant that the international definition of midwife accepted by the World Health Organization, the International Confederation of Midwives, and the International Federation of Gynaecologists and Obstetricians, does not distinguish between midwives who enter the profession with nursing preparation and those who do not. The Directives of the European Community authorize member nations to educate as midwives both those with and those without nursing preparation. Even if a European Community member nation itself provides midwifery education only for nurses, it must permit qualified non-nurse midwives from other member nations to practise as well. Both the international definition and the European Community Directives treat as equivalent midwives who trained first as nurses and those who did not. All are midwives, and all have the same scope of practice, places of practice, and relationships with other caregivers and clients.

According to a 1981 World Health Organization survey, Sweden, Norway, Ireland, Luxembourg, Portugal and Spain restrict entry to midwifery education to nurses. Austria, Belgium, Denmark, France, West Germany, Italy, The Netherlands, Switzerland and England have multiple routes of entry. In the United States, it is not realistic to speak of multiple routes of entry as there are really two separate professions: a small but highly organized profession of nurse-midwifery and a much more diffuse profession that includes both lay midwives and formally trained direct entry midwives. In many states legal recognition has been granted only to nurse-midwives, and in those states midwives who are not nurses practise more or less covertly without regulation. In those states where non-nurse midwives practise legally, they are regulated separately from nurse-midwives.

This international survey indicates that there is no universally held view in the developed world that only nurses should become midwives. To the contrary, the Directives of the European Community indicate a consensus among its member nations that both those who are nurses and those who are not can become equally well qualified midwives. In some countries where entry is restricted to nurses, such as Australia, this model of entry is being challenged (Barclay, 1985), and midwives and their support groups are campaigning for multiple routes of entry. In England, there is a drive to increase the number of direct entry programs.

Nurse Midwifery

In Ontario, the leading proponents of the model that restricts entry to nurses include the College of Nurses of Ontario (CNO), the Registered Nurses Association of Ontario (RNAO), the Ontario Nurses Association (ONA) — the governing body, professional association, and major union of nurses, respectively — the Ontario Region, Canadian Association of University Schools of Nursing (ORCAUSN), which represents the nursing faculties at universities and at Ryerson Polytechnical Institute; the Ontario Medical Association (OMA); and the

Council of Ontario Faculties of Medicine (COFM), which represents medical schools. These organizations have both theoretical and practical reasons for their position.

The CNO, RNAO, ONA, and ORCAUSN all believe that midwifery is a specialty of nursing. For example, the CNO saw midwives as providing

> ...safe, family centered *nursing care* for well women and infants which is integrated into the health care system. The midwife is an independent practitioner who refers, consults, and collaborates with members of various health disciplines, and practises *in accordance with standards established by the College of Nurses* of Ontario. (CNO, submission, p.3, emphasis added)

ORCAUSN stated that "midwifery is a branch of the discipline of nursing just as obstetrics is a branch of medicine" (ORCAUSN, submission, p. 13).

These organizations pointed out the areas of overlap between nursing and midwifery in education and practice. For example, both nurses and midwives engage in health promotion and maintenance, health education, and counselling. The orientation of modern nursing education towards preventive care and family centred concepts was said to fit well with the philosophy of midwifery care. ORCAUSN asserted that recognizing midwifery as a specialty of nursing would ensure public safety and high standards of practice; it said that the well-developed occupational support structure of nursing would be important in maintaining the "newly emerging" specialty's standards.

The nursing bodies warned that consumers might be confused by midwives who are not nurses. They believe consumers will be readier to repose their confidence in nurse specialists than in what they referred to as a new kind of practitioner. Furthermore, in their view, this new practitioner would increase fragmentation of care, from which our health care system already suffers.

The proponents of restricting entry to nurses raised various pragmatic advantages of doing so. They stated that existing faculties of nursing could provide midwifery education programs effectively and economically. Midwives as nurse specialists would appropriately be governed by the College of Nurses, which would save the costs of establishing a new governing body. The many nurses who have trained as midwives in other countries, and who have advanced preparation and experience in maternal/newborn care, would be utilized. The overall costs to the health care system would be less, a very important consideration in this era of constrained government spending in health care. Related to this point was the nursing bodies' concern that establishment of midwifery education programs not divert funds from university-level nursing education programs.

The nursing bodies also said that midwives with nursing preparation would have greater career mobility, and that in some practice settings their ability to perform nursing roles as well as midwifery roles would be advantageous.

The Ontario Medical Association told the Task Force that while a direct entry program could provide midwives with excellent training, integrating these midwives would pose greater problems than would expanding the role of nurses. Expanding the nursing role would represent slow evolutionary change that is modifiable or reversible if need be; in addition, it would be a familiar and flexible approach, adjustable at the local level according to local skills and needs. It would accomplish appropriate modifications in the system at less cost (OMA, letter, Feb. 2, 1987, p.3). The Council of Ontario Faculties of Medicine expressed the view that midwifery education should be at the Master's level for baccalaureate prepared nurses; its explanations focussed on the level of preparation rather than on restricting entry to nurses.

Some hospitals that made submissions to the Task Force, as well as the majority of hospitals surveyed by the Ontario Hospital Association, indicated a preference for nursing preparation — a preference frequently based on the advantage of having the College of Nurses perform licensing and discipline functions for midwifery. We sensed that their preference was also based on the fact that nurses are "known quantities" to them, and may have been affected by the numbers of questionnaires answered for the hospitals by their nursing staff. Two Toronto hospitals with which we had further discussions, Women's College and Doctors, said they would accept well qualified midwives who do not have nursing preparation.

Multiple Routes of Entry

The Association of Ontario Midwives, the Midwives' Association of Canada, and the British Columbia and Alberta Associations of Midwives favour a model in which there are multiple routes of entry to midwifery. They support midwifery education programs that admit students with no prior education in nursing (or any other discipline) and that grant advanced standing to nurses. This model was also supported by the overwhelming majority of consumer and women's organizations, including the National Action Committee on the Status of Women, the National Association of Women and the Law, the Ontario Committee on the Status of Women, the Ontario Advisory Council on Women's Issues, the Consumers' Association of Canada, the Women's Perspective Advisory Committee of the Liberal Party of Ontario, Re: Birth, the Midwifery Task Force of Ontario, the Toronto Women's Health Network, many smaller consumer groups and by the overwhelming majority of individual consumers. Many individual nurses also supported multiple routes of entry.

The proponents of this model advanced pragmatic arguments and arguments of principle. Their starting point is their belief that midwifery is a profession in its own right separate from nursing. They do not agree that midwifery is a specialty of nursing. While they acknowledge that the content of midwifery education programs and midwifery practice overlap with nursing education and practice (as they do with medical education and practice), they say midwifery is an autonomous profession. The midwife, unlike the nurse, exercises *primary* responsibility for the care of women during the reproductive cycle and for the newborn. The midwife assumes responsibility for the conduct of normal deliveries; the nurse does not.

The midwifery groups and other supporters of this model say, further, that educational programs that admit students without preparation in nursing training progams (and to which nurses can be granted advanced standing) are important in preserving the profession's autonomy and the distinctive qualities of midwifery education and practice. They say that much of nursing preparation is not relevant to midwifery. There would be no purpose, for example, to educating midwives in subjects like orthopaedics. Nursing preparation would needlessly extend the cost and duration of midwives' education. At the same time, it would reduce the number of places in nursing programs for nurses who are destined for a nursing career, for some of those places would be occupied by those with a vocation for midwifery.

Many of those who support multiple routes of entry disagree with the statement that the philosophy of modern nursing fits well with the philosophy of midwifery care. They say that nursing's philosophical approach to childbirth is essentially the same as the medical perspective, in which pregnancy and childbirth are viewed as diseases or abnormal conditions, requiring active management by medical experts using a panoply of technological devices. The great strength of midwifery emanates from its different philosophical perspective, which stresses the normalcy and healthiness of childbearing and the mother's right to make decisions about her care at all times. To transform nurses into midwives requires them to "unlearn" attitudes and ideology acquired during their nursing education and nursing practice. Hence, it would be all the more counterproductive to restrict the practice of midwifery to nurses.

The Society of Obstetricians and Gynaecologists of Canada had no strong view on the appropriate entry requirements for the study of midwifery. The Ontario Chapter, College of Family Physicians of Canada told the Task Force that it sees "no significant problem with midwives going directly into training without nursing background as long as the program provides adequate education" (Ontario Chapter, College of Family Physicians of Canada, submission, p. 16). The Medical Reform Group of Ontario favoured multiple routes of entry. The College of Physicians and Surgeons of Ontario said it has no basis on which to make a judgment in regard to the desirability of what it referred to as nurse/midwives over direct entry midwives. It said there is insufficient evidence to prefer one over the other. In its view it would be fair to permit foreign-trained midwives who are not nurses to practise in Ontario, but nurses should not be excluded from practice or forced to repeat all their training.

Having considered these various arguments, we make the following recommendation.

The Task Force recommends that there be multiple routes of entry to midwifery education in Ontario.

We believe that midwifery is an autonomous profession, separate from any other. It is true that the midwife's scope of practice overlaps with the scope of practice of the nurse and the physician. Midwives, nurses, and physicians share certain skills and knowledge. But midwifery is not nursing or medicine. The differences between midwifery and nursing were well described in the following terms by Project 2000, the study group appointed by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting to review the educational preparation for these professions:

> ...Midwifery is a profession different from but complementary to nursing. The role of the midwife can be said to be substantially different from that of the nurse in that the midwife potentially has a greater professional independence as the level of decision-making is of a different order. The midwife is expected to have diagnostic skills relating to both mother and baby that are at one level similar to the obstetrician, and indeed that there is an overlap of skills beween the two [*sic*]. Midwives also have a limited responsibility to prescribe certain scheduled drugs and the right of referral to and discharge from hospital within limitations. All these, together with the need for manual dexterity and to develop the confidence required to function in this way, point to a potentially special and different preparation for midwifery . . . (UKCC, 1986, 6.33)

Both international experience and analysis of the midwife's role and function demonstrate that midwifery is not by its nature a specialty of nursing. The question then becomes: should the model of entry adopted by Ontario convert it into one?

There might be reason to do so if nurses made better or safer midwives. But no evidence was presented to us that this is the case. Perinatal mortality statistics provide no such evidence. For example, the perinatal mortality rates in Sweden and Denmark are about the same, even though all Swedish midwives are nurses and the vast majority of Danish midwives are not. The consensus of opinion in the European Community (as articulated in European Community Directives) is that qualified non-nurse midwives are equivalent to qualified midwives with nursing backgrounds. We see no reason why well prepared midwives without nursing education cannot practise as effectively and safely in Ontario as they do in many other countries.

An important point is missed by both nursing bodies and the OMA, who argue that it is unnecessary and undesirable to add a new practitioner to the health care system. The midwife *is* a new practitioner. Midwives perform a role and function different from the one performed by nurses. This observation applies equally to midwives *with* nursing preparation as to midwives without it.

It seems to the Task Force that the argument that midwives who can also perform nursing roles would be advantageous in some practice settings is not an argument against multiple routes of entry. It is, rather, an argument against *excluding* nurses from midwifery preparation. We agree that nursing preparation in addition to midwifery preparation may be an advantage in some practice settings. One such setting is the remote nursing stations in Northern Ontario, where nurses employed by Health and Welfare Canada provide a wide range of primary health care services, including care of pregnant and postpartum women and occasional emergency deliveries.

But the fact that it would be useful for some midwives to be nurses is not sufficient reason to exclude all others from midwifery preparation. The Norpark survey of midwives identified 30 practising midwives who do not have nursing preparation, 28 of whom said they intend to continue to practise midwifery when it is legalized. The survey identified a further 25 currently non-practising midwives who do not have nursing preparation, 17 of whom said they intend to practise. It is realistic to think that at least some of these midwives have sufficient knowledge and clinical skill to qualify to practise midwifery in Ontario after a reasonable period of refresher education and remediation, which we describe in Chapter 10. We think it is unrealistic to expect the midwives in this group to go through entire nursing programs before upgrading their midwifery preparation. Yet these midwives should not be lost to Ontario.

Neither do we think that the profession should lose people who have a vocation for midwifery, but no desire to spend four years in nursing school first. A vocation for midwifery sometimes develops when a woman has children of her own, or becomes involved in childbirth education. Immigrant women may have functioned as birth attendants in the countries from which they have come. It is difficult enough for mature women, especially those with children, to qualify for a new profession, without having, in effect, to qualify for two. Mandatory nursing education would only deflect them into what many of them might view as an irrelevant educational experience. We think that multiple routes of entry will make midwifery education accessible to a considerably wider group of potential aspirants, and that both the profession and consumers will benefit from their collective breadth of experience.

In pointing out that Ontario has many registered nurses with midwifery preparation obtained in other countries, as well as nurses with advanced preparation and experience in maternal and newborn care, the nursing bodies suggest that there are so many nurses with midwifery preparation that it is unnecessary to prepare non-nurses. The survey of nurses co-sponsored by the Task Force and the College of Nurses, the results of which were not available until well after the nursing groups presented their submissions, indicated that this is not the case. There are indeed between 6,000 and 7,300 registered nurses and registered nursing assistants in Ontario with formal midwifery preparation. However, the survey also indicated that the midwifery education of all but a small number of them is old (80 per cent acquired their education before 1970), and that their practice experience is limited and outdated. The CNO report on the survey commented that the midwifery knowledge and skill of many nurses is so outdated that refresher programs would be insufficient and completion of a basic program in midwifery would be necessary before they could practise (CNO, 1987, p.23).

Furthermore, ORCAUSN, RNAO, and CNO (but not ONA) emphasized that it is the baccalaureate prepared nurse, not the diploma nurse, who has the requisite broad educational background to prepare her for post-graduate midwifery education. This emphasis is congruent with the belief held by these and other Canadian nursing organizations that by the year 2000 the entry level requirement for nurses should be a baccalaureate degree. According to this view, midwifery education, as a specialty of nursing, would then be at the Master's level.

If only baccalaureate level nurses could enter midwifery education programs, the pool of potential applicants would be very small. According to the CNO's statistics for 1985, of the approximately 73,700 registered nurses working as nurses in Ontario only about 8,000 have baccalaureate degrees in nursing and of these, approximately 500 have Master's degrees. The overwhelming majority of practising nurses, over 62,000, have diplomas in nursing. While the CNO cautions that these statistics should be considered approximations, they do provide an indication of the relative proportions of degree and diploma prepared nurses. If midwifery preparation is available only to baccaulaureate prepared nurses, diploma nurses wishing to enter midwifery would first have to attend degree completion programs of two to three years duration. We question how many diploma nurses would be willing to return to school for such a lengthy period. A further effect of such a requirement might be the exclusion from midwifery of nurses trained in countries where baccalaureate programs do not exist. We also question how useful it will be to try to stretch the scarce resources now devoted to degree completion programs to cover both nurses who want to practise as nurses and nurses who are going through the program only to qualify for midwifery training.

We are not convinced that restricting entry to nurses will result in significant cost advantages over the long term, either in education or governance. Providing academic and clinical education in midwifery will require funding whether or not the students have nursing preparation. If nursing preparation at the baccalaureate level is required as a prerequisite to midwifery training, then arguably the resource drain would be greater, because of the large number of nurses who would have to be re-educated as nurses in order to be educated as midwives. The recommendations for midwifery education set out later in this chapter seek to capitalize on the overlap in content areas between nursing and midwifery education through shared courses. With respect to the cost of governance, the implications of our view that midwifery is a separate profession whether or not midwives have prior nursing training must be kept in mind. The College of Nurses might not be the appropriate body to govern the profession of midwifery even if all midwives do have prior nursing education. The administrative costs of a separate governing body can be reduced by sharing support services and office premises with other governing bodies.

Even if it could be demonstrated that restricting entry to nurses would have significant practical advantages, we believe these advantages would be outweighed by a single, compelling disadvantage. Earlier in this chapter we mentioned the U.S. model of midwifery, a model we described in detail in Chapter 2. We are convinced that the inevitable result of restricting entry to nurses will be the creation, or persistence, of an underground profession that is entirely unregulated. The underground profession will consist of midwives with all kinds of educational backgrounds, it will have no enforceable standards of practice, and clients will have very little recourse against incompetent practitioners. It is precisely to safeguard the public by ensuring that all midwives are properly prepared and that they practise in accordance with high standards, that the Government of Ontario has decided to recognize and regulate the profession. Its objective could well be defeated if only nurses are permitted to become midwives.

The nursing profession has much of benefit to share with midwifery. There are individual nurses who deserve the opportunity to qualify as midwives. As we have mentioned and will elaborate on shortly, we hope that the midwifery education programs will be able to share part of the nursing curriculum. We are convinced that the multiple routes of entry model will facilitate nursing's contribution to midwifery, without excluding the contribution of all others. It is the model most consistent with the fact that midwifery is an autonomous profession and it is the model that will best safeguard the public because it will result in the regulation of all practitioners according to a single set of standards.

Midwifery Education

Outline of Structure

Because the model of multiple routes of entry includes people with a wide variety of educational backgrounds, the midwifery education system should be structured to take advantage of these various backgrounds.

The Task Force recommends that midwifery education be provided in a program with two integrated streams:

1) **a four-year stream leading to a baccalaureate degree in midwifery, and**
2) **for those who have university-level preparation in nursing, a 12 to 18 month stream, leading to a diploma in midwifery.**

We believe this structure of education will best provide multiple routes of entry to midwifery education. The baccalaureate stream will be the route to midwifery practice for those with no university level education in nursing, and it will be the core or foundation program for midwifery education overall. In addition to teaching the necessary knowledge and clinical skills, it will nurture in students the distinctive ethos and ideology of midwifery. For those who have university-level preparation in nursing, the diploma stream will offer an expeditious way of obtaining the additional academic and clinical education necessary for midwifery practice. The diploma stream recognizes the breadth of their education in the basic sciences, social sciences, and health sciences, as well as their clinical nursing skills, and will build on this education and experience to provide depth of knowledge and clinical expertise in midwifery.

Although the baccalaureate stream will be established as a comprehensive "direct entry" program for students with no prior relevant post-secondary education — or, indeed, no post-secondary education at all — it will also be the route of entry for people who have relevant post-secondary educational backgrounds. Physiotherapists and nurses with diploma level preparation, for example, will enter the profession through the baccalaureate stream. Their previous education will not have been of sufficient breadth to enable them to enter the diploma stream, but it may well earn them advanced standing in the baccalaureate stream.

It will be crucial to the success of the structure for the baccalaureate and diploma streams to be integrated.

The Task Force recommends that the baccalaureate and diploma streams be offered at the same educational institution, and that courses, teaching and clinical faculty, clinical placement sites and student activities be combined, shared and intermingled.

Only this will prevent the evolution of two categories of midwives — nurses and non-nurses — instead of a single, unified profession. Educating nurses and direct entrants together will facilitate teamwork among them when they are in practice. It will ensure that those with prior nursing training will have the opportunity to acquire the same professional ethos and orientation as midwives trained in the longer program. An integrated structure will make the most efficient use of scarce midwifery teaching resources and clinical placement sites. Students in both streams will benefit from exposure to each other. The end product of both streams will be a single type of practitioner with the same scope of practice — the midwife.

Level of Education

Our recommendation for an integrated diploma and baccalaureate program necessarily implies that the program will be offered at a degree-granting educational institution. The Task Force has carefully considered whether this is the appropriate level for midwifery education.

We note here that a very small number of submissions expressed the view that apprenticeship is the best model of education for midwives. It would ensure that the art, as well as the science, of midwifery is taught, and would enable student or apprentice midwives to remain in their own communities during training. The Association of Ontario Midwives and its sister organizations and the majority of consumer and women's organizations did not support this model of education. The Task Force does not believe that apprenticeship alone is a realistic option for Ontario given the predominance of university and college based education for the health disciplines. Apprentice-educated midwives would not gain acceptance with hospitals or other health professionals. The legitimate concerns about individualized instruction and decentralization can, we believe, be addressed within the formal education program.

In Ontario, 15 universities, the Royal Military College, and Ryerson Polytechnical Institute grant degrees, and 22 Colleges of Applied Arts and Technology (CAATs) grant diplomas. Education for the health professions is offered at both kinds of institutions. Programs for dentistry, pharmacy, optometry, and medicine are offered only at the university level. Programs awarding a degree in nursing are offered at Ryerson and at eight universities, and every CAAT has a diploma program in nursing; both universities and CAATs offer post-RN courses in areas of nursing, usually as part of continuing education programs. One university offers a diploma program in public health nursing for nurses without degrees. The CAATs also offer programs for a variety of ancillary health disciplines, such as ambulance and emergency care, nursing assistant, and dental assistant/hygienist.

The majority of submissions to the Task Force that addressed level of education favoured a university setting for midwifery programs. The Association of Ontario Midwives recommended this on the basis that:

> Formal university training would ensure that each midwife was examined on a standardized body of theoretical and clinical knowledge prior to licensing. The university setting would also allow the development of graduate programs in advanced level midwifery research and education.

The CNO, RNAO, and ORCAUSN all advocated a university level midwifery program for people already qualified as nurses. As a consequence of their view that all nurses should have baccalaureate degrees, and that midwifery is a specialty of nursing, they said midwifery education should be at the Master's level. Because many nurses have only diploma level preparation, they proposed that in the interim, university level certificate or degree programs in midwifery should be offered to nurses.

The College of Physicians and Surgeons of Ontario said the midwifery program should be university based. This was also the view of the faculties of nursing and medicine at several universities. The submission of the Department of Obstetrics and Gynaecology at Queen's University was particularly helpful in pointing out that university programs have well-developed internal and external mechanisms for review and accreditation, through which quality can be assured, and that universities are centres for the development of new knowledge, which enables them to keep teaching programs at the forefront of biomedical knowledge. The department felt that communication among physicians, nurses and midwives would be encouraged by educating their students in a common milieu, whereas fragmentation of care would result if midwives were educated separately from other health disciplines.

The Council of Ontario Faculties of Medicine (COFM) and ORCAUSN said that university-based education was necessitated by the midwife's responsibility for clinical decision-making in the provision of primary and direct care. ORCAUSN said that the broad knowledge base acquired at university would better enable midwives to respond to the needs of diverse social groups. COFM felt that midwives' position in the health care system vis-a-vis other university educated health professionals would be enhanced if they too were "seen as university graduates at an advanced educational level."

Most women's organizations, consumer organizations, and childbirth education groups favoured university level programs for similar reasons.

The Ontario Association of Registered Nursing Assistants favoured basing midwifery education at a CAAT. The various individual CAATs that made submissions to the Task Force, as well as the Heads of Health Sciences (a committee representing health sciences educators at CAATs), felt that CAATs could play a useful role in midwifery education. For the most part this was envisaged as post-RN specialty education.

Our investigation of midwifery education in other countries was not particularly helpful on the question of level of education. In European countries, the system of education for all health professions is quite different from that in North America. In Denmark, The Netherlands and the U.K., Midwifery schools are either affiliated with hospitals or "free-standing" — that is, not affiliated with any post-secondary educational institution. While we did not hear of pressure to affiliate midwifery schools with universities there, we did hear about the scarcity of advanced education and research opportunities for midwives, the kinds of opportunities usually provided at universities. In the United States, all but one or two nurse-midwifery programs are university affiliated, at either the certificate or the Master's level.

The Task Force recommends that midwifery education be based at a university.

We believe that a university is ideally suited to providing comprehensive professional education in which clinical competence is built upon a broad educational foundation. University education is oriented toward producing graduates who can think analytically, apply theory to practical situations, and make independent judgments. Courses in the social sciences, basic sciences, and health sciences, which are an essential part of the midwifery curriculum, are already offered at universities, and can be shared with the midwifery program. Universities tend to attract students with better academic records and wider intellectual interests; we believe they will also attract better applicants to the midwifery programs. Midwifery, as a new profession in Ontario, must gain the trust of consumers and other health professionals. Physicians and nurses must regard midwives as colleagues and peers, and they must be willing to trust their clinical judgment. We believe both consumers and other health professionals may have a more positive attitude toward midwives whose educational preparation is at the university level. The university base will make it possible to offer graduate studies in midwifery in the future, and it will provide opportunities for and encourage research in midwifery. High standards will be assured by university review mechanisms.

Location of Program

Among Ontario's universities are five considered to be health sciences centres that offer multiple health discipline programs and have formal relationships with networks of teaching hospitals. These five health sciences centres are the University of Toronto, McMaster University in Hamilton, Queen's University in Kingston, the University of Western Ontario in London and the University of Ottawa.

The Task Force recommends that the midwifery program be located at one of Ontario's health sciences centres.

In our view, a health sciences centre location will have important advantages for both midwifery and other health professions. It may be possible to arrange cross-appointments of faculty. There will be opportunities for contact among midwifery, medical and nursing students, and among faculty members in the three programs. These contacts will facilitate the integration of midwives into the health care system. The practice of obstetrics and obstetrical nursing will be improved by contact with the philosophy and knowledge base of midwifery. Many British-trained physicians told the Task Force how they had benefited from being taught normal obstetrics by midwives.

It is essential that midwifery education get off to a good start with an integrated program that is widely regarded as excellent. Excellence requires adequate funding, and we believe it is preferable in this instance for all available funds to be concentrated in one place. It will be sufficiently difficult to recruit teaching faculty for one program, probably impossible to recruit them for more than one. While we have found it difficult to estimate the number of midwives Ontario will require (see chapter 9), we believe the number is small enough to be accommodated by one program.

The Task Force is sensitive to the concern that midwifery education be available to students in all parts of Ontario. We were urged by the Thunder Bay and District Health Coalition and the Childbirth Education and Support Group of Thunder Bay to make recommendations that would make it possible for people to train as midwives without leaving Northwestern Ontario. The Coalition submitted:

> We would also like to urge that such a program be established at Lakehead University, where there is already a degree program in at least one health specialty, i.e. nursing. Moreover, the University has satellite programs in several outlying communities and can therefore reach a large number of people. This is important because unless North Western Ontario residents have such a program, most of them will not be able to take advantage of the training. Our inability to attract enough specialists in various areas of health care has been historically true, e.g. rheumatologists, nurse practitioners, speech pathologists, physiotherapists, anesthesiologists, etc. If we cannot train people locally we will not be able to attract the qualified practitioners we need since it is unlikely that enough southern Ontario midwives will want to relocate here.
>
> Even if a degree program is not located at Lakehead University it is important that arrangements for the

internship year should be such that at least part of it would be obtainable in North Western Ontario and other outlying regions.

We do not think it possible to meet the claims of Northern Ontario residents, at least for the present, by locating the midwifery program in Northern Ontario, outside a health sciences centre. However, we do believe the needs of these residents can be met to some degree.

The Northern Ontario Distance Education Access Network was announced by the Minister of Colleges and Universities and the Minister of Education on October 20, 1986. To be established over the next four years, the Network will use correspondence, radio and television broadcasts, audio and video tapes, microcomputers, teleconferencing, and satellite receivers to deliver course material to students and to link them with teachers and institutions in different locations. Community access points will be established throughout Northern Ontario, and regional centres at Thunder Bay and Sudbury will provide coordination.

The Task Force recommends that the Northern Ontario Distance Education Access Network be used in order to make it possible for parts of the midwifery education program to be taken in Northern Ontario communities.

It must be recognized, though, that it will be necessary for midwifery students to be present at the health sciences centre campus for parts of the program.

The Task Force also recommends that clinical components of the programs be arranged in community hospitals and suitable primary health care settings in various locations in Ontario.

Clinical placements close to home will minimize the disruption to students' lives, making midwifery education feasible for a larger number of aspirants. They will increase the likelihood that the midwives will remain in their home communities after graduation. Widely distributed clinical education sites will assist in integrating midwifery in several places in Ontario, because physicians, nurses, and consumers in those places will have contact with midwifery. It is important for student midwives to experience the actual clinical settings in which they will be working after graduation. The facilities and personnel available in many smaller communities are very different from those available in Level III hospitals, and clinical experience confined to Level III hospitals would be inappropriate and inadequate preparation for practice. As well, clinical educational sites in various parts of Ontario will ease the pressure on teaching hospitals, which already accommodate medical students, interns, residents, student nurses, and other learners. It must be recognized, however, that the ability to develop clinical sites depends on the availability of clinical teachers or supervisors. It would be unrealistic to expect every community in Ontario to have suitable, interested supervisors. Nor will there be students in every community, especially during the first few years of the program's existence. It will take time and good will to develop a network of clinical placement sites.

Because there will only be one midwifery program, albeit one with significant distance education and decentralization of clinical settings, it is particularly important that it be accessible from all over the province.

The Task Force recommends that the university not restrict admission, or give preferential admission to applicants who reside in the region from which it ordinarily draws the majority of its students. We recommend that attention be paid to applicants' home communities in an effort to admit qualified applicants from every part of Ontario.

Language of Instruction

Of the five health sciences centres, only the University of Ottawa offers education for the health disciplines in French as well as English. However, not all courses are taught in both languages. French-language nursing education is offered at Laurentian University; other universities offer non-professional courses in French. The Task Force does not believe it is feasible, at least initially, to provide duplicate French and English midwifery education programs because of insufficient resources, both human and financial. However, access to midwifery education for Francophone residents of Ontario can be maximized by utilizing French language courses in the basic sciences, social sciences, and health sciences offered at various Ontario universities, and by arranging clinical placements with Francophone health professionals in Ontario and in other Francophone jurisdictions. We urge that the various universities cooperate to make this possible, by showing flexibility about acceptance of students from the midwifery program; the university sponsoring the midwifery program must in turn be flexible in granting credit to Francophone students for courses taken elsewhere.

The Task Force recommends that academic courses and clinical placements in the French language be arranged on an individual basis for Francophone students and that all universities cooperate to permit this to be done.

In the long run, it should be the aim of the midwifery program to provide integrated French language instruction along the lines now possible at the University of Ottawa.

Selection of Health Sciences Centre

The Task Force does not propose to recommend which health sciences centre should establish the program in midwifery. It would be presumptuous for us to do so.

Members of the Task Force met with senior health sciences administrators at the five health sciences centres. We did a preliminary canvass of each centre's interest in establishing a midwifery program and explored the considerations relevant to their ability to do so. While no commitments were invited or proffered, several centres expressed interest in the idea of establishing a program. We have reason to believe that more than one health sciences centre may be seriously interested in establishing a midwifery program — provided that sufficient start-up and operating funds are made available so that the institutions can respect existing course development commitments (a topic we will return to later in this chapter).

The Task Force recommends that the Ministry of Colleges and Universities select a centre through a competitive tendering process open to all health sciences centres. We recommend that the criteria used in assessing the proposals relate to the recommendations set out in this chapter, including use of the Northern Ontario Distance Education Access Network, use of other universities for French language instruction, integration of the baccalaureate and degree streams, use of clinical education sites in hospitals and primary care locations throughout Ontario, and existence of structures for contacts between midwifery, nursing and medical faculties, and students.

The tendering process must begin as soon as possible because of the time required for such activities as curriculum development, faculty recruitment, and arranging clinical placements.

Student Admissions

There is variation in the admission criteria and processes used in midwifery programs in the countries we surveyed. Nurse-midwifery programs in the U.S. often require applicants to have experience in maternal/newborn nursing. In The Netherlands, the admission procedures include individual psychological assessments to ensure the selection of students with appropriate personal characteristics. By contrast, in Denmark some students are selected solely on the basis of their superior academic achievement, while the majority are selected by lottery from a pool of qualified applicants, and no personal interviews are conducted. Because of this variation, we have surveyed the admissions processes used by Ontario universities offering health sciences education.

We have been impressed by the process used to select students for admission to educational programs in the Faculty of Health Sciences at McMaster University. Every application must include an autobiographical letter or sketch, which, together with the applicant's academic transcript, is assessed by a faculty member, a student, and a member of the community. Selected applicants are then invited to participate in a simulated tutorial. Finally, the applicant has a personal interview with a team of interviewers.

The Task Force has considered whether there should be a minimum age requirement for entry to the baccalaureate program, on the view that the maturity that comes with age is a valuable quality in a midwife. We have concluded that a minimum age requirement would not be appropriate. It could be construed as discriminatory, because age alone does not guarantee maturity, just as youthfulness does not guarantee immaturity. However, we see merit in the policy of many universities of granting admission to "mature students" who do not possess the formal entry qualifications but who have a compensating record of life experience. This admission policy may make midwifery education more accessible to immigrant women as well as native Canadians.

The Task Force recommends that selection of students not be based solely on academic achievement and that procedures used include assessment of applicants' personal suitability for midwifery, including their maturity, motivation, resourcefulness, service orientation and ability to relate to others.

We recommend that admission to the baccalaureate component be considered for students who can demonstrate that their life experience (including work, homemaking, childrearing, and volunteer activities) qualifies them for entry.

Advanced Placement and Course Remission

Universities grant advanced standing in many programs to students whose previous education in relevant subjects meets their standards. Through advanced standing, a qualified applicant may be admitted into the second year of a four-year program. Sometimes advanced standing may be granted on the strength of documentary proof that the student successfully completed courses at another institution. Sometimes applicants are permitted to try challenge examinations, which, if passed, result in course remission, so that the student may take fewer courses to earn a degree or may take additional elective subjects.

In many European countries, both nurses and people without nursing preparation take the same program of midwifery education, with the nurses granted advanced standing. For example, nurses enter the second year of the Danish midwifery program. The Netherlands is the exception in not granting advanced standing in midwifery education programs to nurses.

We believe advanced standing and course remission avoid wasteful repetition. They are advantageous to both students and educational institutions.

The Task Force recommends that advanced standing and course remission be available to students in the midwifery program.

Curriculum

Baccalaureate Stream

The curriculum for the baccalaureate stream will provide academic instruction in the humanities, basic sciences, health sciences and social sciences, as well as intensive instruction in midwifery subjects. It will also teach students to appraise research literature and to apply research findings to practice. Its objective is two-fold: to teach the clinical skills necessary for practice and to provide a broad education in the social and cultural context of birth.

The curriculum has elements in common with the baccalaureate nursing curriculum. Trends in baccalaureate nursing education therefore have relevance to midwifery education. We learned that there is a trend among university nursing schools in Canada toward a "two plus two" year structure. In this structure, the student takes courses in the social sciences, humanities, basic sciences, and health sciences, during the first two years; during the second two years she studies nursing subjects and obtains clinical experience under supervision. Students in other disciplines may take the courses offered during the first two years. The student may postpone her decision whether to qualify as a nurse until after the second year. In addition to its pedagogical advantages, this structure also facilitates career changes; for example, a physiotherapist with the equivalent of the first two years of the program could become a nurse after two more years, with minimal repetition of her previous education.

The Task Force recommends that the baccalaureate curriculum be structured to complement the emerging "two plus two" structure of the baccalaureate nursing program. We recommend that humanities, social sciences, basic sciences and health sciences subjects be concentrated in the first two years, and that midwifery practice subjects be concentrated in the second two years. We recommend that where possible courses be shared with students in other health disciplines such as nursing and physiotherapy.

Diploma Stream

The diploma curriculum will provide academic courses and supervised clinical experience in midwifery subjects, building on the student's knowledge and clinical experience in the sciences (basic, health, and social) and in nursing.

The Task Force recommends that courses be shared with students in the third and fourth years of the baccalaureate stream, and that the clinical placements for diploma students be indistinguishable from clinical placements for baccalaureate students (except the latter will require clinical practice in additional areas of nursing skills).

U.S. nurse-midwifery programs may provide useful models for developing the diploma curriculum.

Clinical Education

The importance of clinical education for midwives cannot be overstated. Many individual submissions stressed that midwifery is an art as well as a science, and that individual instruction is necessary. The curriculum must include sufficient supervised clinical practice, as well as instruction in the theory of midwifery. The clinical education component of the curriculum is all the more important because we are not recommending a period of supervised practice or internship following graduation, during which clinical skills might be learned or refined. Midwifery internships are not the custom in any of the countries we investigated. It is expected that the midwife is fully competent to practise upon graduation and completion of the jurisdiction's licensing examination.

Clinical education for midwifery students must be introduced into a system that already provides clinical education for nursing students, medical students, interns, and residents. This clinical education is arranged by educational institutions, which are now coping with mounting pressures. One major pressure is the difficulty in arranging clinical placement sites for students. Labour and delivery services in teaching hospitals are particularly strained to accommodate the numbers of learners now seeking access to them. This is partly because the rationalization of obstetrical services has concentrated obstetrical beds in fewer hospitals, and partly the result of the declining birth rate. There is a practical limit to how many learners can be involved in the care of any one woman. Many nursing students, medical students, and interns do not obtain clinical practice in obstetrics that is adequate to prepare them for obstetrical practice. We were warned that in the clinical education sites now being used, there may simply be no room for student midwives. While we believe that the relatively small number of midwifery students and their gradual introduction into the system will make their absorption into clinical sites more easily accomplished, the main solution lies in arranging clinical placements in hospitals and other facilities not currently used by large numbers of learners.

The Task Force recommends that community hospitals with Level I and Level II obstetrical services, community health centres, and physicians' offices in various parts of Ontario be used to provide clinical placement sites.

Another pressure faced by educational institutions is the cost of providing clinical instruction and supervision. There is some difference between the way these costs are currently met for nursing students and the way they are met for medical students, interns and residents. In the past, nursing students obtained clinical instruction and supervision for the most part from nurses on the staff of the hospital, who received no additional remuneration for their teaching services. The no-cost element remains true now only for preceptors, nurses who agree to provide one-to-one supervision to advanced year nursing students. For all other clinical nursing training, the universities and CAATs must provide and pay on-site clinical instructors and supervisors. The educational institutions pay them, through a variety of methods, out of the overall funds provided each year by the Ministry of Colleges and Universities.

Clinical education for clinical clerks (fourth year medical students), interns and residents is financed by the Ministry of Health. The Ministry allots a clinical education budget to each hospital in addition to its operating budget. The majority of funds are used to pay stipends to the clinical clerks, interns and residents. Residents are expected to teach and supervise interns and medical students with no additional remuneration. Funds are also provided to the medical schools by the Ministry of Health to remunerate "geographic full-time professors" of medicine (GFTs) for their time, and to pay for a portion of their secretarial expenses. These funds are paid to the medical schools, and are apportioned as they see fit. The Ministry's rationale for paying GFTs is that the time these physicians spend in teaching and supervision reduces their OHIP billings. Although the Ministry of Health's overall clinical education budget for 1986-87 was set at $148,930,000, 85 per cent of this was paid out to clinical clerks, interns and residents. We were told that the medical schools consider the funds available for GFTs and part-time clinical instructors to be extremely inadequate.

As a consequence of this, we were warned in a submission presented on behalf of the Faculty of Medicine at the University of Toronto that, while it believes its Department of Obstetrics and Gynaecology should be involved in the teaching of student midwives, it will be unable to do so without additional resources to compensate instructors.

The approach of the Ministry of Health to funding of clinical education is based in part on the principle that members of a profession have a responsibility to teach the students and junior members of their profession. In our view, this principle can have little application during the early years of the midwifery education program. There will be few qualified midwives available to provide instruction and supervision in clinical placement sites. It will be necessary to recruit nurses and physicians to instruct and supervise midwifery students during this period. Even when midwives become available to act as instructors, we believe there will be a continuing teaching role for nurses and physicians. Just as student nurses, medical students, interns and residents should learn from midwifery instructors, midwifery students should learn from nurses and physicians. In our view, it is unreasonable to expect nurses and physicians to provide any significant amount of clinical education to midwifery students without recompense. It will be difficult or impossible for the midwifery programs to recruit clinical supervisors and preceptors if it is impossible to pay them adequately.

The Task Force recommends that the Ministry of Colleges and Universities or the Ministry of Health make funds available to compensate clinical instructors and supervisors of student midwives.

Another solution to the problem of scarce clinical placement sites and supervisors is to make it possible for students to pursue clinical electives in other jurisdictions. Suitable practice sites exist in the U.S., the U.K., The Netherlands, and Denmark, as well as other jurisdictions where midwifery is well established and English is widely spoken. Clinical electives in France might be made available to Francophone students.

The Task Force recommends that the education program actively seek clinical elective opportunities in other jurisdictions and assist students who wish to take advantage of them.

Clinical experience requirements are common to many midwifery education programs. For example, the Directives of the European Community outline the contents of the Practical and Clinical Training part of midwifery education in the following way:

1. Advising of pregnant women, involving at least 100 prenatal examinations
2. Supervision and care of at least 40 pregnant women
3. Conduct by the student of at least 40 deliveries; where this number cannot be reached owing to the lack of available women in labour, it may be reduced to a minimum of 30, provided that the student assists with 20 further deliveries
4. Assistance with one or two breech deliveries
5. Experience of episiotomy and initiation into suturing
6. Supervision and care of 40 pregnant women at risk
7. At least 100 postnatal examinations and examinations of normal newborn infants
8. Supervision and care of mothers and newborn infants, including pre-term, post-term, underweight and ill newborn infants
9. Care of pathological cases in the fields of gynaecology and obstetrics, and diseases of newborn and young babies

10. Initiation into the care of general pathological cases in medicine and surgery.

In its submission to the Task Force, the Association of Ontario Midwives recommended that student midwives be required to be involved in the continuous care of 50 clients throughout the maternity cycle. The Association proposed a four-year education program, which would be completed in three calendar years. During the first two years, the student midwife would participate in pregnancy and postpartum care and would observe and assist in at least 20 births. In the final year, the student midwife would provide primary care to at least 30 clients under direct supervision.

The Task Force recommends that requirements for graduation include numbers of clinical experiences, including examinations, supervision and care of pregnant women, deliveries, postpartum examinations and newborn examinations. We recommend that the requirements be the same for students in both the diploma and the baccalaureate streams.

It may be wise for the clinical experience requirements to correspond to the European Community requirements in order to provide job mobility for midwives. The governing body should make the final determination of numbers.

Program Size

The determination of class size for both streams will depend on such factors as the number of academic and clinical instructors that can be recruited, the number of clinical placement sites that can be arranged, and the requirement for midwives. We believe there is a virtue in starting with small classes, both from the point of view of program administration and educational excellence, and from the point of view of ensuring that graduates are taken up into the health care system. The fact that it is very difficult to estimate the number of midwives that Ontario requires is additional reason to start with small classes. We think a reasonable initial objective would be to graduate a combined total of between 20 and 30 midwives a year.

Teaching Faculty

We have already mentioned that until Ontario has enough qualified midwives, it will be necessary to recruit physicians, nurses and foreign-trained midwives to provide clinical instruction and supervision. An added problem is created by the requirement of most universities that all faculty members have academic credentials of a certain level. For medicine, this is usually specialty certification; for nursing the minimum credential is a Master's degree. It will be some time before the university itself can mount a graduate program in midwifery. Except for U.S. CNMs, few midwives educated in other jurisdictions have advanced degrees. It may therefore be necessary for the educational institution to be flexible in recruiting faculty members without post-graduate degrees.

Funding

Our consultations with health sciences centres have made it clear that it is extremely unlikely that any university will be willing or able to establish a midwifery education program unless adequate start-up and operating funds are assured. We were told that the usual method of funding new university programs in Ontario will not provide adequate funds. Currently, unless a new program is initiated by the Government, a university wishing to establish a new program is not granted funds to do so in addition to its operating grants. The university must find the necessary funds itself out of operating grants or private sources. Furthermore, operating grants are not paid to the university to mount new health sciences programs unless these programs have been recommended for approval by the Ontario Council on University Affairs and then approved by the Minister of Colleges and Universities. While additional funding is sometimes available for construction and renovation of buildings, the costs of curriculum development, faculty recruitment, and other intangible items must be paid out of operating grants. The health sciences centres pointed out that they are already committed to starting new programs (for example, audiology) without significant special funding. It would be impossible for them to open a midwifery program on the same basis.

It is reasonable to view the midwifery program as a Government initiative. The impetus to establish a program in Ontario clearly originated with the Government rather than with any university.

The Task Force recommends that special funds be allocated for the establishment of the midwifery education program, and that the amount of start-up funds reflects the costs of curriculum design, faculty recruitment and arrangements for clinical placements and supervision, as well as necessary capital improvements such as additional classroom space. We recommend that adequate operating grants also be made available.

Recommendations in This Chapter

1. **The Task Force recommends that there be multiple routes of entry to midwifery education in Ontario.**
2. **The Task Force recommends that midwifery education be provided in a program with two integrated streams:**
   a) a four-year stream leading to a baccalaureate

degree in midwifery, and

b) for people who have university-level preparation in nursing, a 12 to 18 month stream, leading to a diploma in midwifery.

3. The Task Force recommends that the baccalaureate and diploma streams be offered at the same educational institution, and that courses, teaching and clinical faculty, clinical placement sites and student activities be combined, shared and intermingled.

4. The Task Force recommends that midwifery education be based at a university.

5. The Task Force recommends that the midwifery program be located at one of Ontario's health sciences centres.

6. The Task Force recommends that the Northern Ontario Distance Education Access Network be used in order to make it possible for parts of the midwifery education program to be taken in Northern Ontario communities.

7. The Task Force recommends that clinical components of the programs be arranged in community hospitals and suitable primary health care settings in various locations in Ontario.

8. The Task Force recommends that the university not restrict admission, or give preferential admission to applicants who reside in the geographical area from which it ordinarily draws the majority of its students. We recommend that attention be paid to applicants' home communities in an effort to admit qualified applicants from every part of Ontario.

9. The Task Force recommends that academic courses and clinical placements in the French language be arranged on an individual basis for Francophone students and that all universities cooperate to permit this to be done.

10. The Task Force recommends that the Ministry of Colleges and Universities select a centre through a competitive tendering process open to all health sciences centres. We recommend that the criteria used in assessing the proposals relate to the recommendations set out in this chapter, including use of the Northern Ontario Distance Education Access Network, integration of the baccalaureate and diploma streams, use of other universities for French language instruction, use of clinical education sites in hospitals and primary care locations throughout Ontario, and existence of structures for contacts between midwifery, nursing and medical faculties, and students.

11. The Task Force recommends that selection of students not be based solely on academic achievement and that procedures used include assessment of applicants' personal suitability for midwifery, including their maturity, motivation, resourcefulness, service orientation and ability to relate to others.

12. The Task Force recommends that admission to the baccalaureate program be considered for students who can demonstrate that their life experience (including work, homemaking, childrearing, and volunteer activities) qualifies them for entry.

13. The Task Force recommends that advanced standing and course remission be available to students in the midwifery program.

14. The Task Force recommends that the baccalaureate curriculum be structured to complement the emerging "two plus two" structure of the baccalaureate nursing program. We recommend that humanities, social sciences, basic sciences and health sciences subjects be concentrated in the first two years, and that midwifery practice subjects be concentrated in the second two years. We recommend that where possible courses be shared with students in other health disciplines such as nursing and physiotherapy.

15. The Task Force recommends that courses be shared with students in the third and fourth years of the baccalaureate stream, and that the clinical placements for diploma students be indistinguishable from clinical placements for baccalaureate students (except the latter will require clinical practice in additional areas of nursing skills).

16. The Task Force recommends that community hospitals with Level I and Level II obstetrical services, community health centres, and physicians' offices in various parts of Ontario be used to provide clinical placement sites.

17. The Task Force recommends that the Ministry of Colleges and Universities or the Ministry of Health make funds available to compensate clinical instructors and supervisors of student midwives.

18. The Task Force recommends that the education program actively seek clinical elective opportunities in other jurisdictions and assist students

who wish to take advantage of them.

19. The Task Force recommends that requirements for graduation include numbers of clinical experiences, including examinations, supervision and care of pregnant women, deliveries, postpartum examinations and newborn examinations. We recommend that the requirements be the same for students in both the diploma and the baccalaureate streams.

20. The Task Force recommends that special funds be allocated for the establishment of the midwifery education program, and that the amount of start-up funds reflects the costs of curriculum design, faculty requirement and arrangements for clinical placements and supervision, as well as necessary capital improvements such as additional classroom space. We recommend that adequate operating grants also be made available.

Chapter 7

REGULATION OF THE MIDWIFERY PROFESSION

Purpose of the Chapter

The decisions to give legal recognition to midwifery and to make it a self-governing profession make it necessary to establish a regulatory structure for the profession.

Our consideration of the regulatory structure appropriate for midwifery comes at a time when the governance of all the province's regulated health professions is under review. For the past four years, the Health Professions Legislation Review has had under consideration the legislation providing for governance of the regulated health professions, as well as the question of which professions should be regulated. Its proposals, if fully implemented, will alter in many ways the current framework of professional regulation. The appointment to the Task Force of the Review's coordinator, Alan Schwartz, was intended by the Minister of Health to ensure that the Task Force's recommendations relating to governance are consistent with the framework proposed by the Review. Accordingly, before proceeding to outline our proposals for the governance of the midwifery profession, we shall outline the current direction.

Recommendations of the Review

The Review was asked to recommend to the Minister of Health which health professions should be self-regulating. Such a profession is regulated by a governing body composed primarily of elected or appointed representatives of the members of the profession. Typically, the cost of regulation is borne by the profession. The criteria developed by the Review to determine whether a profession should be self-regulating provide an indication of the significance of self-regulation both to the profession and to the public.

The first of the criteria developed by the Review addressed the appropriateness of regulation by the Ministry of Health. The first questions asked were whether the primary objective of the treatments performed by members of the profession is the promotion or restoration of health and whether many of the profession's members are engaged in activities under the jurisdiction of another ministry of government. Next, the criteria assessed the need for regulation. Does a substantial risk of physical or emotional harm to individual patients arise in the practice of the profession? Is the performance of a substantial number of the profession's members monitored effectively either by supervisors in regulated institutions, by supervisors who are themselves regulated professionals, or by regulated professionals who prescribe the profession's services? Is the profession already effectively regulated under an alternative regulatory mechanism, or will it be soon?

The next set of criteria developed by the Review relate to whether regulation of any kind is possible. Standards of practice can be developed and enforced by the governing body only if the members of the profession call upon a distinctive, systematic body of knowledge in assessing or treating their patients, and if the core activities they perform constitute a clear, integrated, and broadly accepted whole. It must be necessary for members of the profession to obtain an appropriate certification indicating successful completion of a post-secondary program offered by a recognized educational institution. The educational program must be available at a Canadian educational institution.

Finally, criteria were developed to assess the feasibility of self-regulation by the profession. Its leadership must have shown that it is able to distinguish between the public interest and the profession's self-interest and that, in self-regulating, it will favour the former over the latter. There must be sufficient willingness among members of the profession to acquiesce in self-regulation so that widespread compliance is likely. The profession must have enough members to staff all the committees of its governing body and to bear the full costs of self-regulation. In addition to running a governing body, the profession must be able to maintain a separate professional association.

On April 3, 1986, the Minister of Health announced that midwifery and 24 other health disciplines will be self-regulating professions. This decision was made even though midwifery has not until now been established as a recognized profession in Ontario. Midwifery satisfies the major criteria for self-regulation in that:

- its primary objective is the promotion of healthy pregnancy and birth.
- midwives are not engaged in activities under the jurisdiction of another Ministry.
- a substantial risk of physical and emotional harm to individual patients arises in the practice of midwifery.
- as autonomous practitioners, midwives are not subject to close day-to-day supervision.
- midwifery is not now regulated effectively.
- midwives call upon a distinctive, systematic body of knowledge, and their core activities constitute a clear, integrated, and broadly accepted whole.
- the leaders of the profession have demonstrated an ability to distinguish between the public interest and professional self-interest, and to favour the former. It must be remembered that the scope for them to act collectively in the public interest has been limited by the profession's lack of official recognition.
- the efforts of the Association of Ontario Midwives and of individual midwives to obtain recognition and to draw up standards of practice and protocols for education and peer review indicate that widespread compliance with self-regulation is likely.

The fact that midwifery is a new profession will raise transitional problems for self-regulation. We will address these later in this chapter.

In addition to addressing the question of which professions should be regulated, the Health Professions Legislation Review is considering a major change in the way the right to practise a health profession is regulated in Ontario. Currently, the regulated health professions have either licensure or registration systems. Under a system of licensure, the governing body of the profession licenses practitioners who meet specified requirements; only licensed practitioners may lawfully engage in the practice of the profession and hold themselves out as members of the profession. Medicine now has a licensure system. Under a registration system, the governing body of the profession maintains a register of practitioners who meet specified requirements; only those listed on the register may hold themselves out as registrants, but practice of the profession is not restricted to them. Nursing now has a registration system. Only registrants may hold themselves out as registered nurses or registered nursing assistants and use the designations R.N., Reg. N. and R.N.A. but non-registrants may engage in nursing practice and call themselves nurses, graduate nurses, and practical nurses.

The Review is considering replacing these two systems with a system that focusses, to a large extent, on licensing certain *acts*. For example, instead of restricting the entire practice of medicine to licensed physicians, the system will restrict the performance of particular licensed medical acts to physicians whose names appear on the register maintained by the College of Physicians and Surgeons of Ontario. Similarly, only nurses named on the register maintained by the College of Nurses will be permitted to perform licensed nursing acts. Activities not specifically identified as licensed acts will be in the public domain and can be engaged in by anyone.

The Review has not yet made any recommendations to the Minister of Health in this area. Any change to the current system will obviously affect the regulation of midwifery. In the interim a decision must be made as to whether midwifery should be regulated either by licensure or by registration.

Licensure or Registration

Both licensure and registration are forms of bestowing occupational credentials. Both are intended primarily to help consumers identify qualified practitioners and to protect consumers from incompetent and fraudulent practitioners. Both credentials may also serve to recognize a body of knowledge and skills, and may provide a basis for rewarding practitioners, and thereby encourage learning and attainment of competency. The key difference between licensure and registration is that licensure confers an exclusive state-granted right to practise and thus a monopoly, whereas registration merely involves state endorsement of competence (Wells, 1971).

Occupational licensure has attracted much criticism in recent years. Some economists hold that the main effect and goal of licensure is wealth maximization for the profession (Hamowy, 1984). Self-governing bodies keep out "undesirables" and limit the number of practitioners, thereby driving up the price of the profession's services. Since licensing requirements often vary from jurisdiction to jurisdiction, practitioners' geographic mobility is limited. Licensure places restrictions on how practitioners of various professions can be utilized and stifles the development of new utilization patterns. Other critics assert that licensure does not achieve its touted objective of ensuring safe practice because when the profession is first granted licensure, the level of practitioners' competence is generally not tested. As well, the continuing competence of members of the profession is not assured, and mechanisms to identify and deal with incompetent practitioners are ineffective. Licensure fosters occupational elitism and prestige, its critics say, and licensing statutes often specify educational requirements so rigidly that they discourage innovation in educational programs. Licensure tends to lead to the proliferation of licensed auxiliary health occupations, each with a narrowly defined scope of practice.Practitioners are locked into defined practice descriptions and have little career mobility.

Licensure for midwives has been criticized on additional grounds. Critics allege that U.S. midwifery licensing laws have tended to impose unattainable educational requirements, with the result that many midwives have been driven underground or out of practice altogether. Licensure deprives consumers of the right to choose caregivers without the requisite qualifications. The standards of practice that come with licensing reduce midwives' independence to practise as they see fit. The profession is co-opted and becomes as elitist and detached from its grassroots as any other profession (DeVries, 1985, 1986; Weitz and Sullivan, 1985; Solares, 1982).

We note that these criticisms have not been raised by the Association of Ontario Midwives, which believes that an effective system of regulation is in the interests of both the public and the profession. The great majority of submissions to the Task Force favoured establishing midwifery as a regulated profession with clearly defined qualifications for practice.

The Task Force recommends that midwifery be regulated through a system of licensure.

This recommendation means that only those midwives who hold licences issued by the governing body will be permitted to practise. Practice without a licence will be a punishable provincial offence.

We think that licensure is necessitated by the risk that incompetent practice poses to women, foetuses, and babies. While simply registering midwives would enable consumers to identify practitioners whose knowledge and clinical competence have been tested, it would not prevent untested practitioners from practising. It would encourage the development of two almost unrelated professions — a fully recognized and integrated one and an isolated "lay" one. Licensure cannot guarantee that all practitioners will maintain their competency or that all incompetent practitioners will be identified and dealt with, but it increases the likelihood. And it will encourage the development of a single midwifery profession. The Task Force's recommendations regarding the Midwifery Integration Program (discussed in the next chapter) will keep unqualified practitioners out of the profession at the start of licensure.

The particular criticisms of licensure of midwives seem to us to be true of any effective method of regulation. The Government's decision to regulate midwifery necessarily implies qualifications for practice and practice standards, and these do limit the "freedom" or at least the range of action of caregivers and consumers. But against unrestricted freedom must be weighed the risk of harm. The challenge is to determine where on the continuum of regulation the balance should be struck: bearing in mind the risks posed by unqualified birth attendants, we strike it at licensure. It must be remembered, too, that the practice of obstetrics is now licensed to the medical profession; the result of recognizing midwifery will be that midwives will share with physicians the monopoly over midwifery/obstetrics. This result theoretically could be achieved by regulating midwifery through a system of registration. However, we think licensing midwives will send a clearer message to practitioners and consumers that practice by unlicensed midwives is unacceptable. It will also enable the governing body for midwives to play a role in enforcing the prohibitions against practice by unlicensed practitioners.

We do not agree that midwifery will inevitably lose touch with its roots if it is regulated; it seems likely to us that the very people and organizations that have helped achieve recognition for midwifery will prevent this from happening. In this and other chapters we recommend mechanisms to ensure a consumer voice in the governance of the profession and in the provision of midwifery services.

Protected Titles

Both licensure and registration systems enable the public to identify qualified practitioners by restricting to them the use of certain titles. The Task Force has considered which titles should be restricted to qualified midwives. To avoid unnecessary confusion, the titles should be the same both during any interim period of licensure and after implementation of the Review's proposals regarding licensed acts. It is important for the titles to be meaningful to the public, and titles should be chosen that will not cause midwives to be confused with any other group. If possible, the titles should signify that midwives are now regulated health professionals. One difficulty is that the term "licensed" will describe acts, not practitioners, if the Review's current thinking remains unchanged. Yet the term "licensed" conveys a clear meaning.

The Task Force recommends that the titles "midwife" and "licensed midwife" be protected titles for the profession of midwifery.

We believe that these titles are clear and unambiguous. Even if a licensed acts system is implemented and all regulated health professionals are technically registered, the term "licensed midwife" will accurately connote that the midwives have a license to perform specified acts that comprise a fundamental component of their scope of practice.

Regulatory Structure

Governing Body

The vehicle for regulation of the self-governing health professions is the governing body. The Task Force has considered whether midwifery should be regulated by a governing body that also regulates another profession or by a separate governing body.

The organizations that advocated recognizing midwifery as a specialty of nursing proposed that midwives be governed by the College of Nurses, which regulates registered nurses and registered nursing assistants. Some of them suggested that the College of Nurses could have a midwifery committee or board with particular responsibilities for midwifery.

The Association of Ontario Midwives and other organizations and individuals whose submissions advocated recognizing midwifery as an autonomous profession, to which there would be multiple routes of entry, recommended that there be a separate governing body.

The Task Force recommends that a new governing body, a College of Midwives, be established to regulate the profession of midwifery.

In Chapter 8, we set out our recommendations for recognizing midwifery as an autonomous profession, with entry open to persons with varied educational backgrounds. A separate College of Midwives is consistent with this model of entry to the profession. There are additional reasons for favouring a separate College. Experience demonstrates that regulation of more than one related profession by a single body can be difficult. In the U.K., where nursing, midwifery, and health visiting are governed by one body, the United Kingdom Central Council, and midwives are greatly outnumbered by nurses (as they will be in Ontario), midwives have sometimes felt that their profession has been misunderstood and neglected. We think that the establishment of midwifery can best be accomplished by a governing body that can devote all its efforts to one profession, all of whose members can be selected for their knowledge and experience in midwifery and fields relevant to midwifery.

The Task Force has considered, but does not recommend, regulation of midwifery by another, established governing body during an initial period of transition. We acknowledge the convenience of borrowing the structures and staff of an experienced governing body. However, it is critical that, from the start, the members and staff of the governing body have expertise relevant to midwifery and that they be free to focus all their efforts on midwifery. It would be unfair to the other profession to ask its governing body to devote considerable resources and effort to midwifery on an interim basis, especially at a time when it may also be struggling to adjust to and implement the changes proposed by the Review. Eventually, governance would have to be spun off to the College of Midwives, and it is preferable for the College and its staff to have the experience to be gained in establishing the profession. Moreover, we think a separate College of Midwives will be more likely to obtain compliance and cooperation from midwives during the critical initial period.

Council and Committees

Under the current regulatory scheme of the *Health Disciplines Act*, and under the Review's proposals, each health profession is governed by the Council of its College. The Council consists of members elected by practitioners, who comprise the majority, and lay members appointed by the Lieutenant Governor in Council; it may also consist of representatives of the educational programs that prepare members of the profession. (It is also possible for the professional members to be appointed rather than elected, as is now the case for the professions regulated under the *Drugless Practitioners Act*.) The Council is responsible for setting the policies and rules by which practitioners are governed. Subject to the approval of the Lieutenant Governor in Council, and with the prior approval of the Minister of Health, the Council may make regulations prescribing classes of licences or qualifications, governing standards of practice, defining professional misconduct, providing for continuing education programs, governing the use of designations and titles, setting fees, and dealing with many other matters. The Council also passes bylaws dealing with administrative and domestic matters.

Members of the Council serve on important committees. The committees vary slightly from College to College, but all Colleges currently have an Executive Committee, a Registration Committee, a Complaints Committee, and a Discipline Committee. The Review has proposed that in addition to these committees, each College have a Fitness to Practice Committee and a Continuing Competence Assurance Committee.

The problem in establishing a College for a new profession is that College business must be performed before there are any licensed practitioners available to serve on the Council. Somebody must perform the functions necessary to license practitioners: examine credentials, set and administer examinations, and establish and apply licensing requirements. Only when a sufficient body of licensed practitioners exists can the Council be composed of a majority of elected members. Accordingly, there must be an interim governing Council.

The Task Force recommends that the Lieutenant Governor in Council appoint 13 members to serve on the Council of the College of Midwives at pleasure. We recommend that the 13 members consist of:

- **one obstetrician**
- **one general practitioner whose practice includes obstetrics**
- **one neonatologist**
- **one nurse whose field of practice is maternal/newborn nursing**
- **one hospital administrator**
- **one childbirth educator**
- **five consumers, representative of women's health organizations, ethnic and visible minority women, Francophone women, and women of Northern Ontario**
- **two lawyers who practise in the fields of administrative law and corporate law.**

The interim Council must be appointed as quickly as possible so that the work of establishing midwifery as a regulated profession can get underway.

Since the Council's functions will inevitably include decisions concerning qualifications for practice and licensure, both in relation to broad policy and in individual cases, it is not appropriate to appoint unlicensed midwives to the interim Council. To do so would potentially cause conflicts of interest, to the discredit of the College and the profession. However, it is important to give prospective midwives a voice with the Council, because their point of view should be heard. Some of them will have had actual practice experience which may guide the Council in its deliberations. Further, midwives are more likely to cooperate with the College if they have had an opportunity to participate in the development of its policies.

The Task Force recommends that representatives be selected from among students in the Midwifery Integration Program and foreign-trained midwives waiting to present their credentials for recognition, to provide liaison and advice to the interim Council.

We believe an interim Council appointed in accordance with these recommendations, listening to the advice of these representatives, will have the expertise and experience necessary to make the Council's first critical decisions informed ones. Nurses, physicians, educators, hospital administrators, and consumers will all have a voice. The lawyers on the interim Council will help to ensure that statutory and common law requirements are observed by the College.

Nevertheless, midwives must join the Council as soon as possible, since the profession is to be self-governing.

The Task Force recommends that three midwives be appointed to the Council as soon as possible, selected from among the midwives licensed after successfully completing the Midwifery Integration Program and foreign-trained midwives whose credentials are recognized. We recommend that the number of places on the Council allocated to midwives gradually increase thereafter, to a maximum of two-thirds of the total number of places. We recommend that the midwives appointed to the Council replace representatives of other disciplines rather than consumers. We further recommend that midwives be elected to the Council, rather than appointed, as soon as their numbers warrant.

Although it is impossible to say precisely how many midwives must be licensed before the majority of members of the Council can be elected midwives, we think several hundred is likely to be sufficient.

As the number of places on the Council allocated to midwives increases, either the total number of places must increase or the number of places allocated to others must decrease. The Review has proposed that the ratio of professional to non-professional places on a Council of a governing body be two to one, so that two-thirds of the members would be practitioners and one-third would not. If the number of places on the Council of the College of Midwives were maintained at 13, this would mean that midwives would take eight or nine places and that those members appointed by the Lieutenant Governor in Council and the education program would take four or five places. It is possible that these numbers may be too small, bearing in mind the Council's workload and the need to staff all the committees. At the same time, the Council must be small enough to function efficiently and at reasonable expense. The Councils of the governing bodies regulated by the *Health Disciplines Act* range in size from 10 members (College of Optometrists) to up to 33 members (College of Nurses).

The Task Force recommends that in the long run the permanent Council of the College of Midwives be composed of between nine and 15 members elected by licensed midwives; between three and five public members appointed by the Lieutenant Governor in Council; and one person appointed by the university that administers the midwifery education program.

Both the interim and permanent Councils must establish and appoint members to committees.

The Task Force recommends that the Council be required to constitute an Executive Committee, as well as committees responsible for Registration, Fitness to Practise, Continuing Competence Assurance, Complaints, and Discipline.

This recommendation is consistent with the proposals of the Health Professions Legislation Review regarding committees.

The Executive Committee carries out the functions delegated to it by the College Council, College by-laws, or by statute, and it deals with matters that require immediate attention between full Council meetings. The Registration Committee considers the eligibility of applicants for licences and may exempt applicants from licensing requirements; it considers every person whose application for a licence the Registrar of the College proposes to refuse, or to whose licence the Registrar proposes to attach terms, conditions, or limitations. The Fitness to Practise Committee considers the cases of physically or mentally incapacitated practitioners and may revoke, suspend, or limit their licences. The role of the Continuing Competence Assurance Committee is discussed later in this chapter. The Complaints Committee investigates and considers complaints against practitioners from patients and other practitioners, and the Discipline Committee hears and determines allegations of professional misconduct and incompetence.

Staff

The key staff member of a governing body is its Registrar. The Registrar is responsible for maintaining a register of licensed practitioners and for issuing licences to qualified applicants. The Registrar may propose to the Registration Committee that a licence be refused or that terms, conditions, or limitations be attached to it. The Registrar may initiate action with respect to incapacitated members and members believed to be guilty of misconduct or incompetence. Ideally, the Registrar of the College of Midwives should be someone knowledgeable about midwifery education.

Governing bodies have additional staff to perform other administrative functions, including maintenance of records, property management, financial control, and secretarial services. Staff are employed to investigate complaints against members, to assist committees, to advise members on matters of practice, to conduct research into matters of interest to the College, and to prepare the College's newsletters and reports. The number of staff members varies with the size of the College's membership.

The Health Professions Legislation Review has suggested that clusters of two or more governing bodies enter into arrangements to share administrative services and office space. Depending on the size and workloads of the governing bodies, even a Registrar might be shared. Such arrangements may enable smaller governing bodies to obtain better administrative services and office facilities than they would be able to arrange on their own. It has been suggested that it is preferable for governing bodies of unrelated professions such as those of respiratory technicians and dieticians to cluster together in order to prevent conflicts of interest from arising for the Registrar and other staff.

The Task Force recommends that the College of Midwives share administrative services, office facilities, and staff with one or more Colleges of unrelated health professions.

Recognition of Midwives with Foreign Credentials

As well as processing applications for licences from graduates of Ontario's midwifery education program, the College will be required to handle applications from midwives formally educated in other jurisdictions. Such applications are likely to be made at the start of the regulatory regime, as an alternative to entering the Midwifery Integration Program (discussed in Chapter 10), and also on an ongoing basis.

It will be the College's responsibility to develop criteria for assessing the qualifications of foreign-trained midwives. The criteria must relate to both educational preparation and practice experience. In considering what these criteria should be, we have examined how nurses and physicians obtain registration in Ontario.

To register as a nurse in Ontario, a foreign-educated nurse must be a graduate of a training program considered by the Council of the College of Nurses to be equivalent to an approved or accredited nursing program in Ontario; she must be currently registered or licensed to practise or eligible to obtain registration or licensure, both in the jurisdiction of current or most recent employment and in the jurisdiction where she was trained; she must have been employed as a nurse within the previous five years; and she must have reasonable fluency in English or French. College staff examine each application individually; since laws pertaining to nursing practice vary, they look for broad equivalencies between the applicant's preparation and what is obtained in Ontario. If the applicant meets these criteria, she is eligible to write the registration examination. The examination must be written within two years of eligibility to do so, and the applicant may make three attempts to pass it.

In its treatment of applications for licensure from physicians educated outside Ontario, the College of Physicians and Surgeons distinguishes between graduates of accredited Canadian and U.S. medical schools, graduates of acceptable unaccredited medical schools, and graduates of unacceptable unaccredited medical schools. Graduates of unacceptable unaccredited medical schools have no opportunity to obtain licensure in Ontario. Graduates of accredited medical schools located in other provinces and in the U.S. must meet the same requirements for licensure as Ontario graduates. Graduates of acceptable unaccredited medical schools who meet certain other criteria are eligible to apply to enter the Pre-Internship Program described in the next chapter of our report; graduates of the Pre-Internship Program are required to complete a further two years of internship and are then eligible for licensure. Physicians in these two groups, as well as Ontario graduates, must pass the national certification examination administered by the Medical Council of Canada. The CPSO regulations serve to allocate a limited number of internship positions available to foreign medical graduates as well as to assure the quality of graduates' preparation.

We think a process similar to the process used by the College of Nurses is suitable to midwifery. Although we recommend in Chapter 10 that a program analagous to the Pre-Internship Program be established to integrate practitioners into the profession at the start of regulation, we do not think that such a program should operate on a continuing basis to assess foreign-trained midwives. In our view, the less costly approach of scrutinizing the educational credentials and practice experience of each applicant will be sufficient to assess competency to practise, bearing in mind that all midwives will also be required to pass the same licensing examination regardless of where they were educated. Furthermore, they (like midwives educated in Ontario but unlike physicians) will work in practice models where they continuously interact with other caregivers, and where the outcome of their work in terms of obstetrical results and client satisfaction is monitored and evaluated.

Some midwives who apply for recognition may lack education or experience in one or two areas of practice although they are generally well qualified. For example, British-trained midwives employed in hospital labour and delivery units may lack current experience in providing pregnancy care. It would be wasteful to require these practitioners to complete the basic midwifery education program. Rather, we envisage that the College of Midwives will advise them to follow a particular course of academic or clinical upgrading.

The Task Force recommends that the College of Midwives establish criteria for recognizing the qualifications of foreign-educated midwives. We recommend that the criteria relate to the equivalence of educational preparation and the recency and relevancy of practice experience.

Licensing Examination

It is customary for governing bodies to require health professionals to pass an examination as a prerequisite to licensure or registration. The examination may be set and administered by the governing body itself, or by an external certifying body. The examination serves as a final assurance of quality; it is an objective way of testing the knowledge of practitioners who are graduates of a variety of educational programs in a variety of jurisdictions.

There are some advantages to having the examination set and administered by an external certifying body. It relieves the governing body of an onerous responsibility, it infuses additional expertise into the quality assurance process, and if the certifying body is national in scope it may encourage the development of uniform nation-wide qualifications for practice. However, for an initial period of time the only Canadian body likely to be in a position to set and administer an examination for Ontario midwives is the College of Midwives.

The Task Force recommends that the College of Midwives set and administer an examination for all midwives who wish to be licensed to practise in Ontario.

The Task Force obtained indications from the American College of Nurse-Midwives and the English National Board for Nursing, Midwifery and Health Visiting that they will assist the College in setting the examination if suitable arrangements can be made. In the future, if other provinces decide to recognize and regulate midwifery, it may be possible to establish a national certifying body separate from any regulatory body.

Continuing Competence

Licensure granted to a midwife at the beginning of her career cannot assure that she will stay competent to practise throughout her professional lifetime. Basic knowledge and clinical skills can be lost, and new knowledge and skills resulting from scientific developments must be acquired. Ensuring that health professionals maintain their competence is a matter of public and professional concern, but there is no consensus about the best method of doing so.

The Health Professions Legislation Review has proposed that every governing body have a Continuing Competence Assurance Committee and that the Committee be required to establish a continuing competence assurance program within five years. The Review has suggested that the program should focus on helping practitioners maintain their clinical competence and should emphasize remediation. Disciplinary sanctions should be available when attempts at remediation fail.

Continuing competence programs can include many different activities, including re-certification examinations, on-the-job assessment of performance, practice audit, self-assessment exercises, peer review, and continuing education lectures and seminars. The reluctance of some governing bodies to make these activities mandatory arises from the concerns that it is difficult to make access to them reasonably available to all members, and that it is often impossible to measure the impact of participation in them on members' competence. For example, attendance at a continuing education lecture does not guarantee that the participant absorbs what is being taught, and if so, applies the knowledge in practice.

The Task Force recommends that the College of Midwives, through the Continuing Competence Committee, establish systems for assuring continuing competence that have the following characteristics:

- **they promote education through the midwife's professional life;**
- **they use meaningful incentives instead of unrealistically harsh sanctions or goals that are too easily met;**
- **they provide reliable assurance of the midwife's areas of continuing competence;**
- **they are acceptable to members of the profession; and**
- **they are updated periodically.**

(adapted from Weisfeld and Falk, 1981)

Enforcement of Legislation

The governing body of a regulated profession generally has the responsibility of enforcing or policing its legislation. Through complaints and discipline procedures it tries to ensure that members comply with the profession's standards of practice. It must also try to ensure that non-members do not engage in activities restricted to members of the profession or hold themselves out as licensed or registered members of the profession. The latter function can be performed exclusively by the governing body, or the governing body can rely on crown attorneys to prosecute offenders. There is merit to both options being available because resources available to the governing body may vary, as may priorities assigned to prosecuting offenders.

The Task Force recommends that the College of Midwives be empowered to prosecute people who contravene midwifery legislation.

This authority should not, however, be exclusive to the College, so that crown attorneys may prosecute offenders in appropriate cases.

The Costs of the College

Ordinarily, the costs of operating a governing body are borne in full by the members of the profession. The governing body's revenues include fees from members, interest earned on its funds, and, if the governing body owns property, rental income. Its expenses include rental of leased premises and office equipment, auditing expenditures, meeting costs (including per diem payments and travel expenses of Council members), legal fees, report preparation, and staff salaries and benefits.

We think it is unlikely that licensed midwives will be able to bear the full costs of College operations for some years to come. If the College does its job properly, its expenses will be in excess of the fees that can reasonably be collected from members. Moreover, there will be expenses associated with starting up and operating the College even before any midwives have been licensed or membership fees collected from them.

The Task Force recommends that the Ministry of Health subsidize the establishment and ongoing operation of the College of Midwives until the profession has sufficient numbers to bear the full costs of College operations.

Recommendations in this Chapter

1. **The Task Force recommends that midwifery be regulated through a system of licensure.**
2. **The Task Force recommends that the titles "midwife" and "licensed midwife" be protected titles for the profession of midwifery.**
3. **The Task Force recommends that a new governing body, a College of Midwives, be established to regulate the profession of midwifery.**
4. **The Task Force recommends that the Lieutenant Governor in Council appoint 13 members to serve on the Council of the College of Midwives at pleasure. We recommend that the 13 members consist of:**
    - **one obstetrician**
    - **one general practitioner whose practice includes obstetrics**
    - **one neonatologist**
    - **one nurse whose field of practice is maternal/newborn nursing**
    - **one hospital administrator**
    - **one childbirth educator**
    - **five consumers, representative of women's health organizations, ethnic and visible minority women, Francophone women, and women of Northern Ontario**
    - **two lawyers who practise in the fields of administrative law and corporate law.**
5. **The Task Force recommends that representatives be selected from among students in the Midwifery Integration Program and foreign-trained midwives waiting to present their credentials for recognition, to provide liaison and advice to the interim Council.**
6. **The Task Force recommends that three midwives be appointed to the Council as soon as possible, selected from among the midwives licensed after successfully completing the Midwifery Integration Program and foreign-trained midwives whose credentials obtained are recognized. We recommend that the number of places on the Council allocated to midwives gradually increase thereafter to a maximum two-thirds of the total number of places. We recommend that the midwives appointed to the Council replace representatives of other disciplines rather than consumers. We further recommend that midwives be elected to the Council, rather than appointed, as soon as their numbers warrant.**
7. **The Task Force recommends that in the long run the permanent Council of the College of Midwives be composed of between nine and 15 members elected by licensed midwives; between three and five public members appointed by the Lieutenant Governor in Council; and one person appointed by the university that administers the midwifery education program.**
8. **The Task Force recommends that the Council be required to constitute an Executive Committee, as well as committees responsible for Registration, Fitness to Practise, Continuing Competence Assurance, Complaints, and Discipline.**
9. **The Task Force recommends that the College of Midwives share administrative services, office facilities, and staff with one or more governing bodies of unrelated health professions.**
10. **The Task Force recommends that the College of Midwives establish criteria for recognizing the qualifications of foreign-educated midwives. We recommend that the criteria relate to the equivalence of educational preparation, and the recency and relevancy of practice experience.**

11. The Task Force recommends that the College of Midwives set and administer an examination for all midwives who wish to be licensed to practise in Ontario.

12. The Task Force recommends that the College of Midwives, through the Continuing Competence Assurance Committee, establish systems for assuring continuing competence that have the following characteristics:

- **they promote education through the midwife's professional life;**
- **they use meaningful incentives instead of unrealistically harsh sanctions or goals that are too easily met;**
- **they provide reliable assurance of the midwife's areas of continuing competence;**
- **they are acceptable to members of the profession; and**
- **they are updated periodically.**

13. The Task Force recommends that the College of Midwives be empowered to prosecute people who contravene midwifery legislation.

14. The Task Force recommends that the Ministry of Health subsidize the establishment and ongoing operation of the College of Midwives until the profession has sufficient numbers to bear the full costs of College operations.

Chapter 8

INTEGRATION OF CURRENT PRACTITIONERS

Purpose of the Chapter

In the foregoing chapters we have outlined our recommendations for the scope of practice of midwifery, educational programs for midwives, and models of practice. We have set out how the midwifery profession should be governed. In this chapter we address how practitioners who are currently providing maternity care to women in Ontario, or who are not currently providing care but have qualifications that might enable them to do so, can be integrated into the regulated profession of midwifery.

Methods of Integration

Whenever a new regime for regulating entry into a profession is established, the status and rights of people who were practising the profession previously are placed at issue. There are three principal ways of dealing with these practitioners.

The first way is to treat them as if they have no qualifications or experience in the profession. If they wish to practise under the new regime, they must meet all the qualifications for new entrants prescribed in the legislation and by the governing body. If they are unwilling or unable to obtain the qualifications, they must stop practising. Usually, this method of integration forces the majority of practitioners either to retire or to go back to school to obtain new educational qualifications. It ensures that everyone practising under the new regime is fully qualified. However, during the time they are obtaining the new educational qualifications, the practitioners cannot engage in practice, with resulting loss in income to them and loss in their services to clients. If spaces in the educational program are small in number, or if the program is inaccessible for reasons of geography or cost, some practitioners will be unable to obtain the necessary qualifications, and their experience and knowledge will be lost to the system. They may even attempt to practise covertly, in defiance of the law.

At the opposite extreme, all the current practitioners of the profession can be treated as if they have all the qualifications required for practice. All practitioners who can prove they were actively practising on a specified date can continue to do so regardless of their qualifications. With this method of integration, there is no disruption in the practice of the profession — practitioners continue to earn their livelihoods and clients are served — but there is no assurance that the practitioners actually have any of the knowledge and experience now considered necessary to practise safely and competently.

The third method of integration seeks a middle ground between these two extremes. It recognizes that some current practitioners have valuable knowledge and experience in the profession. It also recognizes that the consumer demand for these practitioners' services exists and that, if the practitioners are prevented from practising, these consumers will be deprived of their services, and pressures for covert practice will mount. This method appreciates the cost to society of losing qualified practitioners of a developing profession. But at the same time, it recognizes the absolute necessity of testing the practitioners' knowledge and clinical competence.

The Task Force prefers a method of integration that is in this middle ground. There are indeed people in Ontario whose knowledge, clinical skills, and experience in midwifery should not be wasted. The province needs these people to develop the profession: to be the first cadre of qualified practising midwives, to serve in the College of Midwives, and to participate in the education of the second generation of midwives. We also believe the system of regulation could be discredited from the beginning among the community of Canadian midwives and their clients if these practitioners were given no opportunity to prove their qualifications to practise.

But we think it is essential that no one be permitted to practise midwifery without first demonstrating her knowledge and clinical competency. The dangers of incompetent practise are simply too great. Furthermore, hospitals and other health facilities, physicians, nurses, and consumers should not be expected to accept midwives whose competence to practise has not been tested; they should be able to assume that every practising midwife has had her knowledge and clinical skills carefully assessed and adjudged to be acceptable. The credibility of the profession depends on it.

Integration Versus Recognition of Foreign Qualifications

Integration of practitioners at the *start* of a new regulatory regime is easily confused with the recognition or acceptance into the profession, on an ongoing basis, of persons with foreign qualifications. The governing body of every regulated profession must respond to requests for permission to practise from persons who have qualified in the profession in other jurisdictions. For example, every year the College of Nurses receives applications for registration from persons who qualified as nurses in other provinces and countries. Some of these applicants can satisfy the College's requirements and are granted registration; others cannot. Likewise, the College of Midwives will receive applications from midwives who obtained midwifery qualifications in other countries. How we think it should handle these applications is discussed in Chapter 9.

What complicates the matter for midwifery is that some of the people likely to seek integration into the profession at the start of the regulatory regime will have foreign midwifery qualifications. They may present these qualifications to the College of Midwives and the College may recognize them. In other words, this group of practitioners may have two routes to qualify as midwives: they can apply to enter the Integration Program described in this chapter, or they can apply for recognition of their foreign credentials. Practitioners without foreign qualifications in midwifery will have only one route: to apply to the Integration Program. Both groups will be required to pass the licensing examination in order to be licensed.

Groups Likely to Seek Integration

We have attempted to identify all the groups or categories of people who are likely to wish to be integrated into the midwifery profession. We believe this is a necessary first step in devising an effective and administratively feasible integration process. As a result of the surveys conducted for the Task Force by Norpark Computer Design Inc. (Norpark) and the College of Nurses, the Task Force has considerable information about two of these groups.

Currently Practising Midwives

As a result of the Norpark survey, we estimate that there are approximately 50 women currently practising midwifery in Ontario. Norpark estimates that over 80 per cent of them, or at least 40 midwives, plan to practise midwifery after it is legalized. The characteristics of this group were described in Chapter 3—The Current System of Reproductive Care — and the Norpark report appears in Appendix 3. The survey found tremendous variability in the educational preparation and practice experience of these practitioners.

Non-Practising Midwives

Norpark also surveyed 59 midwives who had not practised in Ontario within the past year. Norpark was unable to estimate the total number of non-practising midwives in Ontario and observed that these "are the least well understood group." The educational preparation and practice experience of the non-practitioners surveyed by Norpark was also highly variable. More than half said they intend to practise midwifery in Ontario when it is legalized.

However, it should be emphasized that we do not know whether the non-practising midwives surveyed by Norpark are representative of non-practising midwives in Ontario generally, either in their education and work experience or in their intention to practise midwifery. The information obtained for this group is therefore of limited usefulness.

Nurses

The Task Force and the College of Nurses of Ontario co-sponsored a survey of registered nurses (RNs) and nursing assistants (RNAs). The survey was conducted by the CNO in the summer of 1986.

In 1985, the CNO had requested its 136,000 registrants to complete and return an information slip with their membership renewal forms, indicating whether they were or had been a midwife and whether they had formal or informal midwifery preparation. A total of 5409 registrants reported that they had formal midwifery education. Since only registrants with previous midwifery preparation were asked to return their information slips, and no definition of midwifery was provided on the slip, the accuracy of the response could not be determined.

The purpose of the survey co-sponsored with the Task Force was to obtain more detailed information about the midwifery education and practice experience of those 5400 RNs and RNAs who had reported midwifery training in response to the 1985 survey, and to update, if possible, information about the midwifery background of RNs and RNAs generally. In this survey, the definition of midwifery presented to respondents emphasized the degree of responsibility. To distinguish midwifery experience from experience in other maternity care roles, the definition of midwife in the questionnaire emphasized the degree of responsibility assumed by the midwife in the provision of the full scope of care throughout the reproductive cycle, as well as health counselling and teaching. A complete report on the survey appears in Appendix 3.

Table I summarizes the educational preparation and midwifery work experience of the respondents.

On the basis of the information summarized in Table I, the CNO Report on the survey commented:

> Clearly, the midwifery knowledge and skill of these registrants is, for the most part, outdated and there is an obvious need for refresher courses as well as basic midwifery education programs. It could be argued that the midwifery training of many registrants is so out of date that a refresher program would be insufficient and completion of a basic program should be required for them to resume practice as qualified midwives. (CNO, 1987, p. 23)

It is particularly striking that only about 18 per cent of respondents who expressed interest in practising midwifery have practised as midwives, and that more than 80 per cent of the respondents with education in midwifery acquired it before 1970. The respondents who expressed interest in practising midwifery practised previously in countries with very different models of practice. For example, about one-quarter worked as midwives in the Philippines; in that country midwives work as birth attendants primarily in rural areas outside hospitals, while physicians and nurses attend hospital births (Gates, 1987).

The results of the survey indicated that the actual proportion of CNO registrants with midwifery preparation is higher than the 1985 CNO survey had suggested. The precise number of RNs and RNs with midwifery preparation is unknown, but it is reasonable to estimate that between 6000 and 7200 of CNO registrants have some form of midwifery preparation and that between 3500 and 4200 have had some midwifery experience. Between 900 and 1100 registrants have a definite interest in practising midwifery. Although these numbers are large, it should be emphasized that the survey revealed that the midwifery education of these registrants is, for the most part, outdated and that their midwifery experience is limited.

Physicians

Since the practice of obstetrics is part of the practice of medicine, we see no reason why a physician licensed to practise medicine in Ontario would wish to be integrated into the profession of midwifery. However, several hundred graduates of foreign medical schools live in Ontario, and because of the restricted number of internship positions available to them, the majority of them in recent years have been unable to obtain licensure in Ontario. A number of these foreign medical graduates may wish to integrate into the profession of midwifery.

Others

Although the Norpark and CNO surveys covered the groups most likely to seek integration into the midwifery profession (practising and non-practising midwives; nurses with midwifery preparation and experience), it is quite possible that other people will also wish to integrate. These might include those who have midwifery preparation who are not registered with the College of Nurses, either because they have no nursing preparation, because their nursing preparation has not been recognized by the CNO, or because they have simply preferred not to register. Norpark was unable to estimate the size of this group. In addition, it was suggested to the Task Force that if Ontario becomes the first Canadian province to recognize and regulate midwifery, midwives from other provinces (and, indeed, from all over North America) might come to Ontario, either to practise here or to obtain credentials that might be of some future benefit to them in their home jurisdictions.

Administrative Feasibility

The process of integration must be administratively feasible. The feasibility of a process depends a good deal on the number of people who are expected to apply for integration. The Norpark and CNO surveys suggest that several hundred people have an interest in midwifery and may therefore wish to apply for integration. The integration process must enable a potentially large number of people to be comprehensively and intensively assessed with respect to their knowledge and clinical competency in midwifery. The process should ideally take place in a short time, and its cost, both to the individual and to the government of Ontario, should not be excessive.

Further, the process should be objective, rather than subjective, and its objectivity should be readily apparent. Individuals applying to enter the process and those going through it should feel they have been treated fairly. The public (including other health care providers and hospitals) should have confidence that the knowledge and competency of those integrated into the profession through the process have been rigorously assessed.

The Integration Process

In designing an integration process the Task Force has benefited from learning about the Pre-Internship Program for foreign medical graduates, which is being offered for the first time in 1987. This program was created to enable a small number of graduates of foreign medical schools to obtain internship positions in Ontario, so that they can eventually be licensed to practise medicine in the province. It was designed to help accomplish the government's policy of controlling the number of foreign medical graduates who obtain licensure in Ontario, and to further the mandate of the College of Physicians and Surgeons of Ontario of ensuring that only persons with demonstrated medical knowledge and clinical competence are permitted to intern and practise.

The Pre-Internship Program was organized at the University of Toronto and works in the following way. Graduates of acceptable unaccredited medical schools who have passed the Evaluation Examination administered by the Medical Council of Canada and who are proficient in written and spoken English may apply to enter the Program. Applicants must also meet certain residency and immigration requirements. All applicants with these qualifications may try a written multiple choice examination. The 72 applicants who achieve the highest scores in the examination may proceed to the next stage in the selection process, an Objective Structured Clinical Examination (OSCE).

In the OSCE, the applicants are graded on how they perform specific tasks in 60 "stations". The tasks include history taking and interviewing, problem solving, and interpretation of laboratory data. The tasks and the grading of the applicants' performance of them are structured to maximize the objectivity of the examination and the reliability of its results. Twenty-four of the 72 students are then selected to enter the Program based on their performance in the multiple choice examination and the OSCE.

During the 36 weeks of the Program, the pre-interns will rotate through through medicine, surgery, paediatrics, obstetrics

Table I. Summary of Education and Midwifery Work Experience of Survey Respondents

EDUCATION AND PRACTICE CHARACTERISTICS	TOTAL RESPONDENTS RNs AND RNAs	RN AND RNA RESPONDENTS WHO REPORTED AN INTEREST IN PRACTISING MIDWIFERY
MIDWIFERY EDUCATION	(n = 4514)[1]	(n = 621)[2]
Successful completion of a midwifery education program	89.5% (4025) reported having successfully completed a midwifery education program.	91.3% (567) reported having successfully completed a midwifery education program.
	(n = 4025)[3]	(n = 567)[4]
Location of midwifery preparation	75.7% obtained their midwifery education in the United Kingdom.	61.2% obtained their midwifery education in the United Kingdom.
Length of midwifery program	84.2% of RNs completed programs of 6 to 12 months long; 73.5% of RNAs completed programs of 12 to 24 months long.	79.0% of RNs completed programs of 6 to 12 months long; 73.7% of RNAs completed programs of 2 to 24 months long.
Year program completed	80.8% were educated as midwives before 1970; 0.1% have completed a program since 1980.	80.6% were educated as midwives before 1970; 0.4% have completed a program since 1980.
Educational credential	79.6% received certificates upon completion of their program; 0.3% received a baccalaureate degree.	65.1% received certificates upon completion of their program; 0.5% received a baccalaureate degree.
Program sponsor	79.9% took programs sponsored by hospitals; 10.7% attended independent schools of midwifery.	51.1% took programs sponsored by hospitals; 32.3% attended independent schools of midwifery.
Type of program	All programs combined theory and clinical practice.	All programs combined theory and clinical practice.
Refresher course	8.2% have taken a refresher course	1.6% have taken a refresher course.
REGULATION	(n = 4025)[3]	(n = 567)
Regulatory Credential	49.3% were certified to practise midwifery; 27.3% were registered; 8.4% were licensed.	34.2% were certified to practise midwifery; 46.0% were registered; 15.9% were licensed.

Table I. Summary of Education and Midwifery Work Experience of Survey Respondents (cont'd)

EDUCATION AND PRACTICE CHARACTERISTICS	TOTAL RESPONDENTS RNs AND RNAs	RN AND RNA RESPONDENTS WHO REPORTED AN INTEREST IN PRACTISING MIDWIFERY
MIDWIFERY PRACTICE	(n=4514)[5]	(n=621)[6]
Practised midwifery	51.1% (2308) reported having practised as a midwife.	17.7% (110) reported having practised as a midwife.
	(n=2308)[7]	(n=110)[8]
Total number of years of midwifery practice	72.8% have less than five years midwifery practice experience.	64.6% have less than five years midwifery practice experience.
Recency of midwifery practice	0.6% reported practising asa midwife in 1986; 2.1% have worked as midwives within the past five years.	1.8% reported practising as a midwife in 1986; 11.8% have worked as midwives within the past five years.
Midwifery functions	All functions except "family planning" were performed by more than half of the total respondents.	The respondents in this group did not provide "intrapartum care excluding deliveries or postpartum care" as much as the total respondents; the group performed all other midwifery functions more than the total respondents.
Practice settings	91.8% practised in hospitals; 59.5% have conducted home births; 10.1% worked in outpost health services; 4.4% worked in birthing centres; 2.1% worked in private midwifery practices.	67.6% practised in hospitals; 71.3% have conducted home births; 27.8% worked in outpost health services; 12.0% worked in birthing centres; 26.9% reported private midwifery practices.
Location of previous midwifery practice	61.1% have practised in the United Kingdom; 11.9% have practised midwifery in Canada; 7.4% practised in the West Indies; 3.1% practised as midwives in the Philippines.	26.3% have practised in the United Kingdom; 17.3% have practised midwifery in Canada; 12.2% have practised in the West Indies; 25.5% worked as midwives in the Philippines.

Notes

[1] The total number of RN and RNA respondents (n=4514) was used to calculate the percentage of respondents who reported having successfully completed a midwifery education program.

[2] The number of RN and RNA respondents who want to practise midwifery (n=621) was used to calculate the percentage of this subgroup who also reported having successfully completed a midwifery education program.

[3] The responses of the RN and RNA respondents who successfully completed a program (n=4025) were then analyzed to determine the characteristics of their midwifery preparation. The following percentages were calculated in terms of the group size n=4025.

[4] The responses of the RNs and RNAs who want to practise midwifery and have completed a program (n=567) were then analyzed to determine the educational characteristics of this particular group of respondents. The number of respondents in the group (n=567) provided the base for the following percentages.

[5] The total number of RN and RNA respondents (n=4514) was used to calculate the percentage of respondents who reported having practised as a midwife.

[6] The number of RN and RNA respondents who want to practise midwifery (n=621) was used to calculate the percentage of this subgroup who also reported having practised as a midwife.

[7] The responses of the RNs and RNAs who reported having practised midwifery as defined (n=2308) were then analyzed to determine the characteristics of their midwifery practice. The following percentages were calculated using the group size n=2308.

[8] The responses of the RNs and RNAs who want to practise midwifery and have previously worked as midwives (n=110) were also analyzed to determine the practice characteristics of this particular group of respondents. The number of respondents in the group (n=110) provided the base for the following percentages.

and gynaecology, psychiatry, and primary care/ambulatory medicine. The last 12 weeks of the Program will provide remediation. The pre-interns are placed in teaching hospitals affiliated with each of the province's medical schools and will be assigned to tutors in groups of three. During the Program their clinical performance will be evaluated continuously, and at 16 weeks an OSCE will be used to identify areas requiring remediation. Seminars are provided to orient the pre-interns to the Canadian way of practising medicine. There will be a final OSCE at the end of the Program.

The Pre-internship Program offers an objective, administratively feasible method of evaluating the knowledge and clinical competency of practitioners with varied educational and experiential qualifications. It also provides opportunities for practitioners to improve their knowledge and skill in areas in which they are deficient.

The Task Force recommends that a Midwifery Integration Program with the following characteristics be established for the purpose of integrating people into the profession of midwifery.

Admission Requirements

Any person who meets the following admission requirements criteria may apply to enter the Program:

a. The applicant is a Canadian citizen or permanent resident;

b. The applicant has been a resident of Ontario for at least 12 consecutive months immediately prior to the starting date of the Program;

c. The applicant is proficient in written and spoken English;

d. The applicant has had educational preparation or significant experience in midwifery, maternal/infant nursing, or medicine.

The purpose of restricting admission to Canadian citizens and permanent residents who have resided in Ontario for 12 months is to reserve the limited number of places in the Program to people with a significant residential connection to Ontario. In the formative stages of midwifery, Ontario's resources must be used to establish the profession here, and not to train and credential midwives whose roots and future aspirations are in other parts of the country. We believe that proficiency in written and spoken English is an appropriate requirement for practitioners in view of the fact that the Program, including the written multiple choice examination, the OSCEs, and all clinical work will be conducted in the English language.

However, the Task Force is aware of the Government's commitment to providing French language health services to Francophone residents of Ontario. Ideally, the Midwifery Integration Program should be offered in French as well as in English. We are unable to estimate the number of potential Francophone applicants; the Norpark survey did not identify Francophone midwives, practising or non-practising, and the College of Nurses is unable to identify respondents in its survey who are Francophone. The information provided by respondents in the Norpark and CNO surveys about their country (and province) of education and experience did not disclose significant numbers of midwives or nurses from French-speaking jurisdictions. Nevertheless, the potential for Francophone applicants obviously exists, and if possible they should be included in the Program.

French Language

e. The Midwifery Integration Program should be conducted in both French and English if a sufficient number of Francophone applicants apply for admission.

Finally, the requirement for educational preparation or experience in midwifery, maternal/infant nursing, or medicine is intended to discourage "nuisance" applications from people who have no relevant preparation or experience whatsoever.

Selection Procedures

f. All applicants who meet the admission requirements will try a written multiple choice examination covering the appropriate subject areas in the basic sciences, health sciences and midwifery.

g. All applicants who obtain a specified passing score in the multiple choice examination will take an Objective Structured Clinical Examination (OSCE) covering all areas of midwifery practice.

h. Admission to the Program will be granted on the basis of scores obtained in the multiple choice examination and the OSCE. The number of applicants granted admission at any one time will depend on the number of hospital sites and preceptors available to provide clinical placements and supervision.

Content of Program

i. Students should be placed in hospitals and assigned in small groups to clinical preceptors recruited from nurses, general practitioners,

obstetricians and any midwives whose qualifications have been recognized by the College.

- **j. Students should provide care in all areas of midwifery, including the management of women throughout pregnancy, labour and birth, and the postpartum period. This should include counselling and education.**
- **k. Students should attend seminars on clinical topics, counselling and education, legal issues in the practice of midwifery, ethics and professional responsibility.**
- **l. The program should be structured to permit students to proceed at their own pace.**

Assessment of Competency

- **m. Students should be assessed continuously by their preceptors and others using objective assessment instruments. In particular, their performance of clinical experiences (prenatal and postpartum visits, births and newborn assessments) should be assessed.**
- **n. At about the two-thirds mark in the Program, students should take an OSCE to evaluate their clinical competency and to identify areas needing remediation. A final OSCE should be taken at the completion of the Program.**
- **o. Graduates may apply to the College of Midwives to write the midwifery licensing examination. If they pass it, and if they comply with any additional College requirements for licensure, they will be issued licences to practise midwifery in Ontario.**

Location of Program

The Task Force recommends that the Integration Program be administered by the same educational institution that will administer the basic midwifery education program.

We believe this will facilitate efficient use of clinical preceptors and clinical placement facilities. As is the case for the basic midwifery education program, we believe community hospitals will provide the most appropriate clinical placement sites. It may be possible to arrange placements in a variety of locations in Ontario, depending on the availability of sites and preceptors. The sites developed by the Integration Program can later be used by the basic midwifery education program.

Funding of Program

Adequate funding is required if the Integration Program is to meet its objectives. Funds are required to develop and administer the written examination and the OSCEs, and to pay the clinical supervisors. It is realistic to expect that the funds allocated to the Program will not be unlimited, if only because funds for midwifery education must also be provided for the basic education program. The amount of funding provided to the Program may make it impossible to admit all applicants who have the basic qualifications. If so, we suggest that rationing of places be related to performance in the written examination and OSCEs.

The Task Force recommends that adequate funding be provided to the Midwifery Integration Program by the Ministry of Health and Ministry of Colleges and Universities.

Duration of Midwifery Education Program

The Task Force recommends that the Midwifery Integration Program be offered for a limited time.

The Program is intended to provide a means for the best qualified midwives, maternal/child nurses, and others to integrate into the regulated profession of midwifery. The Program will provide a route of entry to practice that is of shorter duration than the basic midwifery education program. The Program is not intended to serve as a long-term substitute for basic midwifery education. In view of this, and in view of the likely constraints on funding just discussed, we anticipate that the examinations comprising the admission process would be administered only once and that no more than 50 students would graduate from the Program. Individuals who are not admitted to the Program, or who fail to complete it successfully, may apply for admission to the basic midwifery education program.

Midwifery Practice During Integration Program

Many of the students in the Integration Program will have been previously employed or self-employed in midwifery, nursing or other fields. Some will wish to continue to work when they are not specifically engaged in Program activities. Their motivation may be to maintain an income or to continue to provide care to clients, or both. However, until these students are licensed to practise by the College of Midwives, they will have no legal authority to practise midwifery. This will not be the case for nurses whose work activities fall within the scope of nursing practice (as extended, in some settings, by delegated medical acts).

The Task Force recommends that provisional licences not be issued to students in the Midwifery Integration

Program to authorize them to practise midwifery outside the Program.

In our view, until the students have successfully completed the Integration Program and have passed the midwifery licensing examination, there can be no assurance that they are sufficiently knowledgeable and competent to practise safely. Clients who wish to be cared for by students can "follow" them into the supervised setting of their clinical placements.

We acknowledge that this restriction on practice outside the Program will prevent some students from earning income from midwifery practice for its duration. Indeed, students who fail to complete the Program successfully, as well as unsuccessful applicants to the Program, will be unable to continue to practise midwifery and will lose their practice incomes. In our view, this is an unavoidable consequence of the decision to regulate midwifery.

Recommendations in this Chapter

1. **The Task Force recommends that a Midwifery Integration Program with the following characteristics be established for the purpose of integrating people into the profession of midwifery.**

Admission Requirements

a. **The applicant is a Canadian citizen or permanent resident;**

b. **The applicant has been a resident of Ontario for at least 12 consecutive months immediately prior to the starting date of the Program;**

c. **The applicant is proficient in written and spoken English;**

d. **The applicant has had educational preparation or significant experience in midwifery, maternal/infant nursing, or medicine.**

French Language

e. **The Midwifery Integration Program should be conducted in both French and English if a sufficient number of Francophone applicants apply for admission.**

Selection Procedures

f. **All applicants who meet the admission requirements will try a written multiple choice examination covering the appropriate subject areas in the basic sciences, health sciences and midwifery.**

g. **All applicants who obtain a specified passing score in the multiple choice examination will take an Objective Structured Clinical Examination (OSCE) covering all areas of midwifery practice.**

h. **Admission to the Program will be granted on the basis of scores obtained in the multiple choice examination and in the OSCE. The number of applicants granted admission at any one time will depend on the number of hospital sites and preceptors available to provide clinical placements and supervision.**

Content of Program

i. **Students should be placed in hospitals and assigned in small groups to clinical preceptors recruited from nurses, general practitioners, obstetricians and any midwives whose qualifications have been recognized by the College.**

j. **Students should provide care in all areas of midwifery, including the management of women throughout pregnancy, labour, birth and the postpartum period. This should include counselling and education.**

k. **Students should attend seminars on clinical topics, counselling and education, legal issues in the practice of midwifery, ethics and professional responsibility.**

l. **The program should be structured to permit students to proceed at their own pace.**

Assessment of Competency

m. **Students should be assessed continuously by their preceptors and others using objective assessment instruments. In particular, their performance of clinical experiences (prenatal and postpartum visits, births and newborn assessments) should be assessed.**

n. **At about the two-thirds mark in the Program, students should take an OSCE to evaluate their clinical competency and to identify areas needing remediation. A final OSCE should be taken at the completion of the Program.**

o. **Graduates may apply to the College of Midwives to write the midwifery licensing examination. If they pass it, and if they comply with any additional College requirements for licensure, they will be issued licences to practise midwifery in Ontario.**

2. **The Task Force recommends that the Integration Program be administered by the same educational institution that will administer the basic midwifery education program.**
3. **The Task Force recommends that adequate funding be provided to the Midwifery Education Program by the Ministry of Health and Ministry of Colleges and Universities.**
4. **The Task Force recommends that the Midwifery Integration Program be offered for a limited time.**
5. **The Task Force recommends that provisional licences not be issued to students in the Midwifery Integration Program to authorize them to practise midwifery outside the Program.**

Chapter 9

THE POTENTIAL REQUIREMENT FOR MIDWIVES

Purpose of the Chapter

The Task Force has often been asked how many midwives we think Ontario will require. The question is obviously important; its answer bears on such issues as the number and size of education programs for midwives, the viability of a governing body, the availability and price of professional liability insurance, and the overall cost to the health care system of midwifery services. However, for several reasons the question is difficult to answer. Many factors are likely to affect the potential requirement for midwives. The evidence with respect to some of these factors (such as public and professional attitudes toward midwives) is scanty. The impact of other factors (such as the practice settings available to midwives) depends on decisions yet to be made. In the circumstances, we think it is most useful to discuss the signposts indicating general directions in the requirement for midwives, and to estimate the number of midwives that might result if various options are pursued.

Factors Affecting the Requirement for Midwives

Number of Pregnancies and Births

The number of births in a year in Ontario might be viewed as the upper limit of the requirement for midwifery services. In fact, it is not the best estimator: the ratio of births to pregnancies is not one-to-one because of pregnancy losses and multiple births. However, statistics on pregnancies are not collected; instead, demographers count the number of babies born in a year. The office of Economic Policy, Ministry of Treasury and Economics, estimates that if Ontario experiences moderate fertility and moderate immigration and emigration, there will be an average of 129,000 births per year until 1991, and an average of 118,000 per year between 1991 and 2006.

Some consumers told the Task Force that all pregnant women should have access to midwives, regardless of whether other practitioners are also caring for them, because all women can benefit from a midwife's counselling and emotional support. However, midwives are usually considered to be appropriate caregivers for healthy, low risk pregnant women, while women whose pregnancies have complications obtain primary care from physicians. The Ontario Medical Association and the provincial Advisory Committee on Reproductive Care have estimated that approximately 85 per cent of pregnancies can be categorized as low risk, capable of being managed by general practitioners (whose obstetrical scope of practice is similar to midwives') and that a further 12 per cent can be categorized as moderate risk, capable of being managed by general practitioners in consultation with obstetricians and other medical specialists. This suggests that 85 per cent of pregnant women could obtain primary care from midwives, and that an additional 12 per cent could be cared for by midwives in consultation with medical specialists. The upper limit of the requirement for midwives as primary caregivers could therefore be estimated as 109,650 births per year until 1991 (85 per cent of 129,000) and 100,300 per year (85 per cent of 118,000) thereafter.

Since midwives perform normal, vaginal deliveries, and not operative deliveries (involving the use of forceps and vacuum extractors) and caesarean sections, it is also possible to estimate the requirement for midwifery services by focussing on the percentage of all deliveries represented by non-operative vaginal deliveries. According to Ministry of Health statistics, between 1983 and 1986 non-operative vaginal deliveries constituted an average of 67.8 per cent of all deliveries in Ontario. If midwives performed all the non-operative vaginal deliveries in Ontario, they would therefore perform approximately 87,540 deliveries per year until 1991, (67.8 per cent of 129,000) and approximately 80,000 per year (67.8 per cent of 118,000) thereafter.

Of course, both these theoretical upper limits are unrealistically high. Some of the 85 per cent of pregnancies assessed as normal at their outset will develop complications requiring medical attention, and some will require operative deliveries performed by obstetricians. Some of the normal, vaginal births will have been preceded by high risk pregnancies requiring medical management. Moreover, these births must be shared with other providers of reproductive care.

Other Providers of Reproductive Care

In Ontario today all women have access to reproductive care provided by physicians and nurses. For some women, such as those in Northern Ontario, access to care is often inconvenient, and the Task Force heard from women in all parts of Ontario who were critical of the reproductive care they had received. Nevertheless, primary care by general practitioners or obstetricians (or, for native women in northern communities, by nurses) is available throughout Ontario, and almost all births are attended by physicians. Postpartum health teaching and counselling are provided by public health nurses, while childbirth education programs are organized by boards of health and other community organizations.Thus, the requirement for midwifery care represents a transfer to midwives of a requirement that, in theory, is currently being met by general practitioners, obstetricians and nurses. The actual availability of care will have a major bearing on whether this transfer occurs. Different factors are affecting the availability of care from general practitioners and obstetricians.

General Practitioners

As we discussed in Chapter 3, the proportion of general practitioners engaged in obstetrical practice in Ontario is declining. Ministry of Health data based on OHIP billings indicates that in 1985-86, approximately 70 per cent of Ontario's general practitioners conducted no deliveries, an increase from 62 per cent in 1983-84 and 67 per cent in 1984-85. The percentage of all deliveries performed by general practitioners declined from 50 per cent in 1974-75 to 31.5 per cent in 1985-86, although they still performed 43.8 per cent of vaginal deliveries in 1985-86. The statistics tend to understate the involvement of general practitioners in overall reproductive care, because many of them provide some pregnancy care to their patients, referring them to obstetricians for delivery. This is reflected in Ministry data indicating that in 1985-86, general practitioners billed OHIP for more pregnancy care services than did obstetricians (713,547 services versus 642,351), even though they performed fewer deliveries (40,798 versus 87,153) (Ministry of Health, 1987). Nevertheless, there is no doubt that general practitioners are playing a diminishing role in the provision of reproductive care.

There appear to be various reasons for this, including inadequacies in the obstetrical training received by many general practitioners, their desire for an easier lifestyle, increases in fees charged by the Canadian Medical Protective Association to physicians engaging in obstetrical practice, the fear of malpractice litigation over an unfavourable obstetrical outcome, and the level of the fees paid by OHIP for obstetrical care (Canadian Medical Association, 1987). Although the Canadian Medical Association, the College of Family Physicians of Canada and the Ontario Medical Association have been exploring these causes and considering what can be done to reverse the trend, it is uncertain that it can be reversed or even halted. If in the future fewer and fewer general practitioners provide obstetrical care, their patients may require midwifery services.

Obstetricians

It is unlikely that all the pregnant women who in the past were cared for by general practitioners can be cared for by obstetricians. Many observers predict a shortage of obstetricians in the future. In fact, in Northern Ontario, there is already an apparent shortage of obstetricians. According to the Underservice Area Program of the Ministry of Health, whose mandate is to place physicians in underserved communities, obstetricians are being sought by virtually every community.

Obstetricians have, as we noted earlier, already assumed a larger role in normal obstetrics as general practitioners have withdrawn from obstetrical practice; their activities have also been expanded by scientific developments. In the aftermath of the dispute between the Ministry of Health and the Ontario Medical Association over Bill 94 (which removed the right of physicians to "extra-bill" their patients more than fees paid by OHIP), some obstetricians predicted that the level of fees paid by OHIP would induce many obstetricians to stop providing obstetrical care to low risk women, leaving the field open to midwives.

The number of new obstetricians entering practice in Ontario depends on immigration to Canada, migration from other provinces, and the number of obstetricians trained in Ontario. This in turn depends on the number of obstetrical residency positions funded by the Ministry of Health, a number that has declined from 99 in 1980 to 89 in 1986. It has been estimated by a Liaison Group of the Ministry and the Council of Ontario Faculties of Medicine that as many as 40 more obstetrical residency positions are needed to meet the province's needs to 1990. However, in arriving at this estimate, the Liaison Group did not consider the possibility of other practitioners such as midwives providing care to healthy pregnant women. It does not currently appear that the number of obstetrical residency positions will be increased.

Even if it were possible for obstetricians to care for all pregnant women and perform all deliveries, many observers would view this as undesirable. It is costly for a society to prepare and use more highly trained practitioners to care for women who could be cared for equally well by less highly trained practitioners. Moreover, there is some evidence that transferring pregnant women from the care of general practitioners to obstetricians tends to result in more obstetrical interventions (Klein, 1983). Some obstetricians do not wish to provide obstetrical care to low risk women; they feel they are specialists in complications and medical conditions associated with pregnancy.

Nurses

The availability of nurses to provide reproductive care is also likely to affect the requirement for midwives. Since the midwife's role overlaps with the role of the obstetrical nurse, changes in the deployment of nurses may influence the requirement for midwives. Community health centres, boards of health and physicians may add midwives to their staffs in order to increase or alter the range of services they can offer. For example, a board of health in a community with an increasing use of early postpartum discharge may seek a midwife to make the necessary postpartum visits to assess the condition of the mother and baby.

In hospitals, midwives might be hired as permanent staff members, particularly in services where there are large numbers of normal births. Midwives could monitor and support women in labour and provide skilled delivery care. Midwives might be recruited to a hospital staff to augment nursing positions or, if it becomes difficult to recruit and retain experienced obstetrical nurses, to replace them.

Nurses who prefer the role of primary caregiver may be attracted to midwifery and seek educational opportunities to qualify as midwives. The impact of this on the availability of obstetrical nurses and the demand for midwives versus nurses is impossible to predict.

Attitudes toward Midwives

Consumer Attitudes

Whether a pregnant woman chooses to be cared for by a midwife will depend in large part on her attitudes toward pregnancy and birth and toward various caregivers. If she does not consider a midwife to be a suitable caregiver, she may insist on being cared for by a physician even if it means great inconvenience. Unfortunately, we could obtain little information on the attitudes of women in Ontario toward midwives.

In January of 1986 an omnibus public opinion survey conducted by Environics Research Group Limited included, at the request of the College of Nurses, three questions related to midwifery. One thousand and seven interviews were conducted with a stratified sample of men and women over age 18 living across Ontario. To the question "Have you recently seen or read anything about the issue of midwifery?" 50 per cent answered affirmatively. To the question "Would you say you are strongly in favour, somewhat in favour, somewhat opposed or strongly opposed to legalizing the practice of midwives delivering babies in Ontario?" the responses were:

Strongly in favour	21%
Somewhat in favour	40%
Somewhat opposed	17%
Strongly opposed	17%
Depends/qualified	2%

Sixty-one per cent of respondents were to some degree in favour of legalizing midwifery. Respondents who said they had recently seen or read something about midwifery tended to be in favour of it more than those who had not.

The third question, "If midwifery were legalized in Ontario, do you think this practice should be restricted to registered nurses with specialized training or should it be open to anyone with specialized training?", produced the following responses overall:

Nurses only	55%
Anyone	41%
Neither/doctor only	2%
No opinion	3%

Fifty-four per cent of respondents who were in favour of legalizing midwifery were willing to accept as a midwife anyone with specialized training.

Another public opinion survey conducted by Environics in August of 1986 included a question somewhat related to midwifery sponsored by the Ontario Hospital Association. The question asked where deliveries of babies should take place after midwifery is legalized. The results were:

Only in hospitals	26%
Birth clinic/hospital	21%
Home/clinic/hospital	43%
Combination/other	5%
Not sure/don't know/no answer	5%

Although not a comprehensive treatment of midwifery, the two Environics surveys are somewhat suggestive. They suggest that the public attitude toward legalizing midwifery is favourable and that the attitude toward where midwives should deliver babies is flexible. However, we are aware of no survey that has asked women of childbearing age the much more pertinent question of whether, if they became pregnant, they would wish to be cared for by a midwife during pregnancy, labour and birth.

The several hundred individual members of the public who made submissions to the Task Force were overwhelmingly in favour of giving legal recognition to midwives. Many women who made submissions to us were satisfied consumers — indeed, proselytizers — of midwifery care. Furthermore, the model of midwifery practice endorsed by the majority of them was, in a sense, the most radical alternative to the existing system of care: they said the midwife should be an autonomous professional, with a unique scope of practice, providing primary care to her clients. We realize that the views expressed in these submissions may not be representative of the views of the whole population; it was obvious that the men and women who took the time and made the effort to write submissions and attend public hearings were highly committed to midwifery. However, their views were echoed in submissions we received from such broadly based organizations as the Consumers' Association of Canada, the Ontario Committee on the Status of Women and the National Action Committee on the Status of Women, as well as from such diverse special interest groups as Women Working With Immigrant Women and R.E.A.L. Women of Canada.

The majority of hospitals, district health councils, and medical and nursing organizations also told the Task Force that they believe there is consumer demand for midwives. Some organizations and individuals understood the demand as expressing a preference on the part of knowledgeable consumers for an alternative kind of care, while others viewed it as a result of the withdrawal from obstetrical practice by general practitioners. Some northern Ontario District Health Councils thought midwives would respond to the needs of northern women for more accessible health care, and one southern Ontario District Health Council thought midwives would be particularly helpful to Old Order Mennonite women.

Midwives told the Task Force that they believe there is a large demand for their services in Ontario. Half the midwives who made individual submissions said they had entered the profession because of consumer demand for their services. However, it is difficult to assess the level of the demand for their services from data obtained in the Norpark Computer Design Inc. survey. The 34 practising midwives who participated in the survey reported they saw an average of 35 clients a year and conducted an average of about 22 deliveries a year. While a caseload of 35 clients and 22 deliveries a year is small, this might not be the result of a lack of demand. It might result from such factors as practice setting (a midwife in a location where no back-up is available might choose to keep her caseload small) or the midwife's desire to work part-time. From another point of view, the level of demand indicated by the average caseload statistics is quite large, bearing in mind midwifery's lack of legal recognition, its unfamiliarity, and the fact that midwives cannot provide care in hospitals.

The appointment of the Task Force and the public hearings we held in October and November 1986 generated considerable media interest in midwifery. Coincidentally, early in 1986, the CBC broadcast a television drama about a woman choosing to give birth at home attended by a midwife. Media attention in itself might be interpreted as indicating that editors and programmers believe the public want to read and hear about midwifery. More importantly, media attention raises public awareness of midwifery, for the public opinion survey results discussed earlier indicate that people who are aware of midwifery are more likely to be in favour of it. In our view, given the length of time midwifery has lacked recognition in Ontario, the dearth of information about it available to the general public, and its association in the public mind with home birth, the level of public support for midwifery is, if anything, surprisingly high.

Physicians' Attitudes

By itself, consumer demand for midwifery alone may be insufficient to bring about its integration into the health care system. Midwives also need the support of physicians, who are powerful figures in establishing and changing hospital policies and protocols. For midwifery practice to be safe and effective, physicians must be willing to consult with midwives and receive referrals from them. Physicians must be involved in midwifery education. Physicians are also potential employers of midwives. Our health care system is physician oriented, and many pregnant women are likely to consult their general practitioners for advice on whether they should seek care from a midwife or an obstetrician. For all these reasons, the positive attitudes of individual physicians and organizations toward midwives will influence the integration and subsequent requirement for midwives.

A survey conducted in the fall of 1986 by Dr. Paula J. Stewart of the Department of Epidemiology and Community Medicine of the University of Ottawa, and Dr. Jim M. Beresford, Chief of the Department of Obstetrics and Gynaecology at Ottawa Civic Hospital, investigated the attitudes of all physicians then attending births in Ottawa-Carleton. Seventy-eight physicians were surveyed, of whom 49 per cent were general practitioners and 51 per cent were obstetricians. Eighty-five per cent were men, and approximately two-thirds had graduated from medical school more than 10 years ago.

In response to the question "Do you think that midwives meeting certain standards should be licensed to provide obstetrical care in Ontario?" the results were:

Yes	46%
No	36%
I don't know	18%
No response	3%

Seventy-three per cent of the women physicians were in favour of licensing midwives, compared to 42 per cent of the men. Physicians who had worked with midwives (41 per cent said they had worked with them in other countries, either during training or in practice) were twice as likely to support licensure as those who had not (67 per cent compared to 33 per cent). Of the physicians favouring licensure, 57 per cent thought the public would benefit from the introduction of midwifery services, 29 per cent did not know, and 14 per cent thought the public would not benefit. Almost half thought midwifery would have a positive impact on their own practices by allowing them to concentrate on high risk obstetrics, provide better care to their patients with midwife assistance, and continue to be involved in obstetrics.

By contrast, the physicians who were opposed to licensure believed that there would be no benefit to the public or to their practices if midwives were licensed. Slightly more than half thought there would be no impact on their practice, and one-third thought there would be a negative impact by decreasing the size of their practice or forcing them out of obstetrics.

As Table 1 demonstrates, the physicians were generally cautious about the functions they envisioned midwives performing.

Table 1: Services physicians practising obstetrics in Ottawa-Carleton thought midwives should be licensed to provide in Ontario

Service	No. (% of Total)
Pregnancy	
Pregnancy care on her own	10 (14%)
Pregnancy care shared with a physician	60 (85%)
Labour	
Monitoring labour on her own	21 (30%)
Monitoring labour under the supervision of a physician	56 (79%)
Prescription of drugs to relieve pain in labour	10 (14%)
Birth	
Assisting at the birth of the baby on her own	24 (34%)
Assisting at the birth of the baby under the supervision of a physician	48 (68%)
Suturing of first or second degree lacerations or episiotomies	31 (44%)
Postpartum	
Immediate postpartum care	55 (77%)
Late postpartum assessment (4-6 weeks)	41 (58%)
Discussion of family planning options	51 (72%)
Prescription of methods for family planning	13 (18%)

The authors of the study commented:

> Most physicians see midwives having the same responsibilities which nurses presently have in the office, in the caseroom and on the postpartum floor, but slightly expanded. Many physicians expressed ideas about the level of responsibility of the midwives which were consistent with an expanded role for the nurse through midwifery, while maintaining physician supervision. This is not surprising given that this is the natural step beyond what is currently being done. There is a smaller group of physicians who favour more autonomy for midwives, and see them functioning in a similar capacity as general practitioners do now — assuming primary responsibility for providing care to low risk women with physician backup as necessary.

Twenty-eight per cent of the respondents thought a physician should be present in the birth room during a midwife-assisted birth, 57 per cent thought the physician should be on-site in the hospital, and 14 per cent thought the physician could be off-site, but should be on call. Fourteen per cent thought midwives should be licensed to provide assistance at home births for low risk women.

The physicians' opinions with respect to acceptable practice models are depicted in Table 2.

Table 2: Practice models which physicians practising obstetrics in Ottawa-Carleton thought would be acceptable for midwives practising in Ontario

Practice Model	No. (% of Total)
Midwives are employed by the hospital	42 (58%)
Midwives are paid through OHIP and work in a joint practice with physicians with whom they share the responsibility for providing care	25 (35%)
Midwives are paid through OHIP and work in a joint practice with physicians, but as independent practitioners	3 (4%)
Midwives are paid through OHIP and work in a solo or group midwifery practice	5 (7%)
Other	7 (10%)

We have reported at length the results of the Ottawa-Carleton physician survey because to our knowledge, it is the only Ontario survey of physicians' attitudes toward midwifery. In our view, it is encouraging that almost half the physicians surveyed were in favour of licensing midwives. It is noteworthy that the results indicate the same pattern as in the responses to the College of Nurses/Environics public opinion questions: physicians familiar with midwifery are much more likely to be in favour of it than those who are not. This suggests to us that there is a base of physician support for midwifery, and that support will grow as physicians become more knowledgeable about midwifery and more familiar with midwives.

Hospital Attitudes

As we have suggested earlier, the attitudes of hospitals — or more accurately, hospital boards, administrators, and medical and nursing staffs — toward midwives will significantly affect the requirement for their services. Hospitals are potential employers of midwives. As well, in deciding whether or not to grant privileges to community-based midwives, to enable them to attend births in hospital (if the necessary statutory amendments are made), hospitals will affect the requirement for midwives indirectly by influencing midwives' practice settings and the range of services they can offer.

In July 1986, the Ontario Hospital Association conducted a survey of its active members. Responses were obtained from individuals in executive positions, nursing, and medicine representing 86 hospitals. Eighty-seven per cent believed that there would be a public benefit in providing midwifery services. Almost half believed midwifery would lead to more positive personal relationships between clients and caregivers, 37 per cent believed the public would benefit from a choice of birthing alternatives, 13 per cent thought midwifery would reduce obstetrical interventions and produce safer and better labour and delivery service, and 12 per cent thought midwifery care would be cheaper.

The international definition of midwife, which the Task Force recommends be adopted in Ontario, was considered appropriate for Ontario by 71 per cent of hospitals. Sixty-seven per cent were in favour of the midwife as private practitioner with joint admitting privileges with a physician, 54 per cent were in favour of midwives being employed by hospitals as staff members, and 13 per cent favoured the midwife as private practitioner based in the community with her own hospital admitting privileges. However, 64 per cent were opposed to requiring every hospital with an obstetrical unit to offer a midwifery service; many hospitals felt that a midwifery service would be impractical for a small hospital or obstetrical unit, and some felt that a small population base could not support a midwifery service.

The positive attitudes toward midwifery indicated in the OHA survey were echoed in submissions we received from several hospitals interested in starting midwifery services. Six hospitals expressed keen interest in establishing a midwifery service or adding midwives to a family practice unit or proposed birthing centre. These hospitals, together with the Chedoke-McMaster Nurse-Midwifery Project, would require a total of approximately 25 to 30 midwives. In our view, the level of support for midwifery among the OHA hospitals generally is particularly encouraging because they are aware of the changes in hospital routines and relationships that the integration of midwifery will bring about.

Scope of Practice

The scope of practice granted to midwives will clearly influence the requirement for their services. We think the broad scope of practice we are recommending is likely to increase the requirement because of the wide range of services midwives will be competent to perform. The autonomy with which they practise will enable them to be primary caregivers for women with low risk pregnancies, and therefore a true alternative to physician care for a proportion of women. If midwives are granted a narrower scope of practice, so that the range of services they can provide is narrower, and if they are not permitted to practise autonomously, then the requirement for them may be smaller.

Models of Practice and Practice Settings

The requirement for midwives will also be affected by the range of practice models and work settings available to them. Where midwives practise and their relationships with other caregivers are likely to influence some women in their choice of caregiver. For example, a number of women who had used midwives in the past indicated to the Task Force that it was important to them that their midwife was willing to help them give birth at home. The fact the midwife was a private practitioner based in the community rather than in an institution also seemed to be attractive to them. Midwives might not be attractive caregivers to these women if they were restricted to working in institutional settings and could not attend home births. At the same time, we have no doubt that the overwhelming majority of women who wish to give birth in hospitals (and, when they are established, birthing centres) will not choose to be cared for by midwives if they cannot be attended by them there.

Continuity of care is very important to women. Indeed, many women who had used midwives extolled the almost total continuity of care that had been provided to them. In most cases, the woman had been seen throughout her pregnancy by the same midwife, or by a back-up midwife almost equally well known to her, and this midwife and her back-up had stayed by her side throughout labour and birth. This degree of continuity, together with the unhurried pace of the appointments during pregnancy, created a warm, sometimes intensely personal, relationship between woman and midwife. Continuity of care usually carried over into the postpartum period, when the midwife would visit the woman at home to monitor her condition and to help her adjust to the new baby.

We think that practice models that enable midwives to provide continuity of care and to develop rapport with their clients will respond to what women are seeking in midwifery care and will therefore increase the requirement for midwives. Practice models in which midwives are unable to provide continuity of care (for example, where they are restricted to labour and delivery services and have no contact with women during pregnancy or after birth) or in which they are unable to give much personal attention, will not respond to what women are seeking and are thus unlikely to increase the requirement for midwives.

Cost

In the commercial marketplace, cost or price is a key determinant of demand for goods and services. In the health care market, cost affects consumer demand only to the extent that consumers must bear it out of their own pockets. Many submissions to the Task Force stated that unless midwifery services are insured under OHIP, less affluent women will be unable to use midwives. This would obviously affect the overall requirement for midwives.

The cost of various health care services also affects the demand for their providers from potential employers, including hospitals and physicians. The fate of the nurse-practitioner in Ontario provides a vivid example of this. Because no payment mechanism was devised to enable physicians who bill OHIP on the basis of fee-for-service to recoup the cost of employing nurse-practitioners, employment opportunities for nurse-practitioners have been largely eliminated among these physicians.

The Task Force's recommendation, set out in in Chapter 5, that the Ministry of Health fund approved midwifery services in both institutional and community-based practice models, will almost eliminate cost as a factor affecting consumer and employer demand for midwives. Instead, the key factor will be the amount of money the Ministry of Health allocates to midwifery services. The impact of the allocation on the numerical requirement for midwives will be affected by midwives' productivity and the level of their remuneration.

Productivity

Midwives' productivity in a health care system is affected by how they are deployed. For that reason, it is impossible simply to apply to Ontario the productivity rates achieved by midwives in other jurisdictions. In an attempt to predict the productivity of midwives in Ontario we estimated the number of hours of contact between a midwife and a typical client during pregnancy, labour, birth, and the postpartum period. This estimate appears in Table 3. We caution that our estimate is based only on some reported experiences; it has not been validated by research.

Table 3: Estimated Number of Contact Hours Per Midwife Client

Service	No. of Hours
First pregnancy visit	2.00
Visits during pregnancy	6.50
Labour and birth care	12.00
Postpartum visits, hospital and home	5.00
Examination at sixth postpartum week	0.05
Total	26.00

A nurse employed full-time is usually paid to work 1950 hours per year. If midwives work the same number of hours per year, and provide 26 hours of care to each client, each midwife will be able to provide care to about 70 clients per year. The 1820 total contact hours of care provided by the midwife in a year will be supplemented by the time required to perform other functions, such as charting and travel, and to engage in practice-related activities, such as continuing education and peer review.

This caseload may appear to be small compared with the number of patients physicians care for in a year. On the basis of 1985-86 OHIP statistics, we calculate that the "average" Ontario obstetrician performs about 145 deliveries a year, including operative births and caesarean sections. Of course, obstetricians also have gynaecology patients. However, the caseload must be considered in light of the nature of midwifery care, which differs from physician care.For example, while a pregnant woman's appointment with a physician ordinarily lasts about 15 minutes, in our analysis we allotted considerably more time for each appointment with a midwife. And while a physician is usually intermittently present in the labour and delivery room, a midwife is ordinarily present throughout active labour and the birth.

Estimating the Requirement for Midwives

It is possible to estimate the number of midwives that will be required by dividing the total number of births expected to be attended by midwives by the average caseload per midwife. The validity of the estimate largely depends, of course, on the accuracy of the estimate of the total number of births expected to be attended by midwives; in this chapter we have discussed the various factors influencing this. We said that, for several reasons, the percentage of normal pregnancies and the percentage of normal, vaginal deliveries were unrealistically high upper limits to the proportion of births expected to be attended by midwives.

We think a more realistic upper limit is 40 per cent of births, which is approximately the percentage of births attended by midwives in The Netherlands. The Dutch experience is noteworthy because midwifery is well established in The Netherlands and government policies actively support the profession. Furthermore, Dutch midwives practise in the way we envisage midwives practising in Ontario, providing continuity of care through the full scope of practice.

The requirement for midwives changes if the average caseload per midwife is higher or lower than 70 births per year. In The Netherlands, there is a difference of opinion between the government and many midwives over what is a reasonable caseload. The government thinks a reasonable caseload is approximately 150 births a year but the midwives think 100 births a year is more reasonable, if they are to provide good care and also enjoy family lives. Some Ontario midwives told us that 50 to 60 births a year is reasonable. Table 4 depicts the number of midwives that would be required to attend 40 per cent of births if each midwife cared for 50, 70, or 100 clients per year.

Table 4: Number of midwives required for 40 per cent of births if each midwife cares for 50, 70, or 100 clients per year

1988-1991

Caseload	Number of Midwives
50	1,032
70	737
100	516

Based on 40 per cent of 129,000 births per year

1991-2006

Caseload	Number of Midwives
50	944
70	674
100	472

Based on 40 per cent of 118,000 births per year

Obviously, midwives will not care for 40 per cent births in Ontario immediately. There will not be a sufficient number of midwives for this to happen for some time. It will take time for the Ontario public to become educated about the midwife's qualifications and the nature of midwifery care. In the United States where government policies are relatively neutral toward midwifery and CNMs and non-CNMs have failed to develop a significant role for themselves among the mainstream of American women, midwives handle approximately five per cent of births. Five per cent might therefore be viewed as the lower limit to the proportion of births midwives will attend in Ontario.

Table 5 depicts the number of midwives required to attend between five and 40 per cent of births if each midwife cares for 70 clients a year.

Table 5: Number of Midwives Required for 5, 10, 20, 30 and 40 Per Cent of Births if Each Midwife Cares for 70 Clients per Year

1988-1991

Percentage of Births	Number of Midwives
5	93
10	186
20	372
30	558
40	737

Based on 129,000 births per year.

1996-2006

Percentage of Births	Number of Midwives
5	84
10	168
20	336
30	504
40	674

The numerical requirements stated in Tables 4 and 5 refer to midwives working full-time in clinical positions. Some midwives are likely to work part-time for at least part of their working lives and some may take breaks in their careers. Some midwives will work in administrative and teaching positions. There will be drop-outs from midwifery as there are from every profession. Therefore the number of people who must qualify to practise as midwives, if the Province's requirements are to be met, is greater than the numbers appearing in the Tables.

On the basis of our estimates, we think a reasonable objective is the formation of a pool of 50 qualified midwives within the first two years after implementation. These will be graduates of the Midwifery Integration Program and foreign-educated midwives whose credentials are recognized by the College of Midwives. These 50 will be available to fill positions in hospitals and medical practices where interest in employing midwives has been expressed.

The midwifery education program may begin to produce graduates after 18 months of developmental work. If it produces 20 graduates in the third year after implementation, 20 in the fourth, and 30 in the fifth (graduates of the diploma stream and others who were granted advanced standing in the baccalaureate stream), at the end of five years there will be a pool of approximately 120 midwives. The first class to complete the entire four-year baccalaureate stream will graduate in year six, adding another 30 midwives to the pool. This pool should be sufficient to provide care to women representing between five and 10 per cent of births. If we project that midwives will attend 20 per cent of births in the early years of the next century, the education program will be required to graduate a further 150 to 250 midwives, or 30 to 50 a year, depending on the number of foreign-educated midwives licensed to practise in Ontario, to meet the province's requirements.

The Task Force does not apologize for the approximate nature of these estimates. It will take time before accurate assessments of the demand for midwives and their productivity can be made. Yet proper assessments must be made if educational resources are to be utilized efficiently and to avoid either a glut or a shortage of midwives.

Level of Remuneration

The Task Force was not directed to recommend an appropriate level of remuneration for midwives, and we shall not do so. However, in Chapter 5 we recommend that in order to obtain Ministry approval, proposed practices should be required to demonstrate that the midwives will be paid at a fair and reasonable level. We said the level of remuneration should take into account the level of the midwives' responsibility, the demands on their time, and the difficulty of their work. In this section we shall suggest the range within which midwives' remuneration might fall.

The level of remuneration (which will constitute a significant component of the global operating budgets provided by the Ministry of Health) is likely to be established partly by comparing midwives with other health professionals. In 1986 OHIP fees paid to physicians for pregnancy, labour, birth and postpartum care totalled about $600 for normal pregnancies concluding in vaginal births. If midwives are paid at the same rate, and on the basis that they care for 70 clients year, their annual compensation would be about $43,000. However, the fees paid to physicians are intended to cover overhead expenses as well as personal income, and while midwives will have overhead expenses too, these are likely to be lower than those incurred by most physicians. The $43,000 should therefore be reduced by a certain amount to reflect this fact. On the other hand, the fact that midwifery care is more time-intensive than medical care could be considered a reason to increase it.

Entry level general duty nurses (including labour and delivery room nurses) working in hospitals in which nurses are represented by the Ontario Nurses' Association currently earn $30,300 a year. The maximum basic salary earned by nurses with seven years experience is $34,526. Nurses with baccalaureate degrees in nursing receive an additional educational allowance of about $80 a month. The starting salary of a nurse with a baccalaureate degree is therefore about $31,000. In our view, nursing salaries would be inappropriate for midwives because of the nature of the midwife's level of responsibility, the difficulty of her work, and the greater (and less predictable) demands on her time.

These comparisons to physicians' and nurses' remuneration suggest that midwives' remuneration should be somewhere between approximately $31,000 and $43,000. A similar analysis, with a similar result, was conducted in Quebec by the Groupe de travail sur la profession de sage-femme. It concluded that midwives are comparable to pharmacists, bearing in mind the length of their education, the level of their responsibility, and the demands on practitioners' time. This would result in midwives in Quebec being paid about $35,000 a year.

Cost-Effectiveness of Midwifery Care

In allocating money to midwifery services the Ministry of Health will be interested in their cost-effectiveness. Supporters of midwifery often claim that midwifery care is more cost-effective than physician care. This is said to be so because midwifery education will be less costly than medical education, because midwives will be paid less than physicians, because midwives rely less heavily on expensive electronic monitoring, tests, and medication, and intervene less often, and because midwives' clients remain in hospital for shorter periods of time after giving birth.

A Quebec Interministerial Committee on Midwives calculated the savings to be obtained from the fact that midwives would be paid less than physicians (Quebec, 1983). The committee assumed that midwives would be paid the same salaries as nurses, which in 1981 was $483.80 per week, and that they would attend at two births per week. The cost of their professional services could therefore be calculated as $241.90 per birth. The fee paid to general practitioners in Quebec in 1981 for the same package of services was $511.90. Assuming that hospitalization costs were $1,656.00 per birth for both midwives and general practitioners, the total cost of a birth attended by a midwife would be $1,897.90, compared to $2,167.90 for a general practitioner. The saving for each birth attended by a midwife would be $270.00.

This cost comparison assumed that midwives would provide care to significantly more women in a year than we feel may be reasonable (104 births versus 70). Furthermore, it did not include the cost of any visits to a physician during pregnancy. In Chapter 4 we recommend that every pregnant woman be seen by a physician twice; under the 1986 OHIP Schedule of Benefits, these two visits would cost a total of about $58.00. This cost should be added to the cost of midwifery care when comparing it to the cost of care provided by physicians.

A recent U.S. study compared the relative efficiency of three different types of clinics providing reproductive care to low income Mexican-American women living in rural, medically underserved areas of Texas (Seiner and Larson, 1985). One clinic utilized CNMs and nurses to provide pregnancy, childbirth and postpartum care and operated an in-patient birthing centre for normal births; the CNMs had arrangements with outside general practitioners and obstetricians for consultations and referrals. The second clinic utilized salaried physicians and nurses to provide care, and births were attended by the physicians in a local hospital. The third clinic utilized public health nurses and a part-time CNM to provide limited pregnancy and postpartum care, and clients had to make their own arrangements with outside physicians for childbirth care. The authors measured each clinic's cost-effectiveness by dividing the total operating and capital costs of pregnancy care by the total number of visits. It found the first clinic was most cost-effective; that is, its cost per visit was lowest. The major reason for this appeared to be its use of the lower-wage CNMs and nurses instead of physicians.The third clinic was least cost-effective and the cost-effectiveness of the second was between the first and third. There were no significant differences in the quality of the care provided by the three clinics.

Another U.S. study compared the hospital charges generated by CNMs and physicians in a Salt Lake City hospital for women who had had normal pregnancies and births (Cherry and Foster, 1982). The average hospital bill for the CNMs' clients *was $114 lower than the average bill* for the physicians' clients. This was primarily due to the shorter average length of stay in hospital (1.5 days versus two days) and increased use of the less expensive birthing room by the midwives' clients after birth. There were no significant differences in the condition of the babies after birth; during labour, the midwives' clients received significantly less anaesthesia.

Another recent study compared the costs of childbirth care in The Netherlands relative to the place of birth and type of birth attendant (Butler and Lapre, 1986). It examined the costs generated by midwives, general practitioners and obstetricians in home births, hospital births and policlinical births (in which the mother gives birth in hospital and is discharged with the newborn within 36 hours of birth). The study concluded that variation in the place of birth played a larger role in cost differences than variation in the type of practitioner. The differences in the fees paid to the three types of practitioner in The Netherlands are small. The study found that policlinical births are 13 per cent more expensive than home births, even when both are attended by midwives, and hospital births are 62 per cent more expensive than policlinical births, even when both are attended by obstetricians. In other words, there are considerable cost differences when the place of birth changes, even when the type of practitioner is held constant. The study attributed the cost differences to the content of care in the various locations. The authors also commented that savings could be obtained by reducing the average length of stay in hospital after birth.

The cost savings associated with midwifery care reported in these studies were primarily related to the fact that midwives are paid less than physicians, and that home is a less expensive birthplace than hospital. Hospital is more expensive than home partly because of accommodation costs, but also because of the content of the care provided in hospitals.

In the view of the Task Force, it is premature to predict that cost savings will result from the integration of midwifery in Ontario. It does seem reasonable to predict that care of a quality equal to that provided by physicians can be provided by midwives at no greater long-term cost to the health care system. The evaluations that we recommend be conducted by all midwifery practices should enable judgments to be made in the future about the cost-effectiveness of midwifery. In conducting these evaluations it is important that a broad definition of effectiveness be used. As the authors of the Dutch study point out:

> Sometimes there is a tendency in the health field to perceive the effectiveness of care to be directly linked with the level of training or specialization of the practitioner, the complexity of the procedures used and the expenses of care. Pertaining to obstetrics it has been observed that midwives provide elements of care, such as psychological support and nutrition counselling, sometimes neglected by obstetricians, and that certain functions like managing low risk pregnancies may be less competently performed by overqualified people. (Butler and Lapre, 1986)

Planning to Meet the Requirement for Midwives

Since midwives, general practitioners, obstetricians and nurses all provide care to childbearing women, it seems evident that human resources planning for these professional groups should be coordinated. If the impact of decisions about midwifery on other professional groups is not considered, the allocation of resources for education and services is unlikely to be as rational as it might be. Midwifery services may then be regarded as an added expense to the health care system to which there is no corresponding cost-saving.

Recommendations in this Chapter

1. **The Task Force recommends that the Ministry of Health and the Ministry of Colleges and Universities coordinate human resources planning for midwifery, nursing and medicine.**
2. **The Task Force recommends that nursing, medical, and midwifery bodies that address human resources planning in submissions to government consider the role played by the other professions in providing maternal and infant care.**

Chapter 10

IMPROVEMENTS TO REPRODUCTIVE CARE

Purpose of the Chapter

In the course of investigating how midwifery should be implemented in Ontario, the Task Force obtained considerable information about the condition of the overall system of reproductive care. Despite the system's impressive achievements in improving obstetrical and neonatal outcomes, we heard many opinions about what could be improved. Many consumers who made submissions in support of implementing midwifery criticized the care they had received from physicians and nurses. Some consumers explained how their dissatisfaction with hospital care had led them to give birth at home. Medical and nursing organizations told us that introducing midwives will not correct problems caused, in their view, by such systemic factors as persistent underfunding of health care and the malpractice litigation crisis. They identified excellent initiatives in reproductive care that they felt should be supported, quite apart from the introduction of midwifery. Individual practitioners described the obstacles they face in their day-to-day efforts to provide good care. Some of these concerns have been touched upon in Chapter 3, which describes the current system of reproductive care. A more detailed summary of consumer concerns is found in Appendix 2.

Although the Task Force was not directed to consider how the overall system of care might be improved, we think it is important to share what we have learned. The suggestions here derive from our observations about what is good in Ontario practice as well as what can be improved. We stress that we heard from (and about) many organizations and practitioners who are striving to improve the quality of care; some of their efforts are mentioned in Chapter 3. Here we seek to encourage others to emulate them, and we offer some concrete suggestions about how they might do so. Although these suggestions are aimed primarily at hospitals, physicians, and nurses — those now providing the major portion of obstetrical care — when midwives enter the official health care system, they of course should also be guided by them.

Improvements to the System

The Task Force believes that reproductive care in Ontario can be improved in the following ways:

1. **Physicians, nurses and hospitals can pay greater attention to the psychological and social needs of childbearing women and their families.** It must be clearly understood that meeting these needs is not a frill. Some needs — such as the need for privacy and quiet in the delivery room — can surely be met within existing resources; they simply call for staff to display sensitivity and good sense and to remember that what is a routine experience for them is unique for the parents. Other needs may require additional resources. For example, labour room nurses should have one-to-one relationships with women if they are to coach and support them through labour, and physicians must be adequately compensated for their time if unhurried pregnancy care is to be provided. Facilities must be available in hospital for rooming in of mother and newborn. Special attention should be paid to helping women who suffer a loss, such as miscarriage, stillbirth, or neonatal death or who approach a pregnancy with fear because of previous losses. Birth attendants should be aware of the cultural dimension of childbirth and especially attuned to the expectations and needs of women of ethnic communities and native Canadians. Public health nurses should pay particular attention to how new mothers are coping with the psychological and social stresses of motherhood. Medical and nursing educators should address psychological and social needs in every part of the medical and nursing curriculum.

2. **Greater continuity of care can be provided.** We think ways can be found to compensate for the fact that many physicians work in groups and have on-call arrangements with other physicians. For example, during pregnancy women can be given opportunities to meet all the physicians who may attend them at birth and written birth plans can be used to record and communicate their wishes and expectations.

3. **Hospitals can permit greater flexibility in routines and protocols.** It should be possible for medical and nursing staff to vary routines and protocols to meet the wishes of women and their families. While there may be little leeway in some clinical matters, in other matters, such as who accompanies the woman during labour and choice of birthing positions, the woman's wishes can be granted. It is equally important for staff to communicate the hospital's rules in a clear and consistent manner, to avoid confusion and disappointment.

4. **Hospitals can focus their efforts on improving care through people rather than decor.** Basic physical conditions should be present (for example, no woman should have to labour in a semi-private room and it should be possible to labour and give birth in the same room) but assuming they are, it is more important to have sufficient numbers of nurses than it is to decorate birthing rooms. Family-centred maternity care depends far more on people's attitudes than on the physical setting for birth.

5. **Structures can be created to channel the views of consumers to hospital personnel in responsible positions.** Hospitals should actively seek criticisms and suggestions about medical and nursing care from parents. Women with complaints should not be dismissed as problem patients. Questionnaires and personal inter-

views with recently discharged women can be used to elicit comment, and it may be possible to convene group discussions with parents and key nurses and physicians.

6. **In every hospital one person can be assigned responsibility for effecting improvements.** Mrs. Shirley Post, former Executive Director of the Canadian Institute of Child Health, told the Task Force that what separates hospitals that provide good family-centred maternity care from those that do not is often a single person who takes responsibility for bringing about improvements. The person designated by the hospital should have influence with both the medical and nursing staffs, and should have knowledge about clinical matters as well as the psychological and social needs of childbearing women and their families.

7. **Hospitals can establish forums for effective communication between medical and nursing staffs.** Communication between the two key professional groups may help clarify the obstetrical service's objectives and help form a consensus about its philosophy of care. This, in turn, can lead to improvements in care. At the least, good communication may discourage the tendency to assume that responsibility for a matter always lies with the other profession.

8. **Resources both inside and outside hospitals can be used to obtain consistent high quality obstetrical care that responds to community needs.** The Perinatal Outreach Program of Southwestern Ontario plays a valuable role in making recommendations and suggestions for change in clinical practice. Other regions of Ontario could benefit from programs of this type. They could be administered by regional perinatal advisory committees, which we hope will be re-established. The Ontario Hospital Association might further develop its role in providing leadership and education to hospitals in practice areas, by, for example, developing and disseminating "Good Birthing" guidelines; this could be done alone or in concert with professional and consumer organizations already active in the field. Hospitals can develop links with community agencies and self-help groups; Doctors Hospital in Toronto has found such links to be essential to the provision of culturally sensitive care.

9. **The general practitioner's role in obstetrics can be strengthened and supported.** The decline in the general practitioner's role in normal obstetrics and the movement of low risk obstetrical patients to obstetricians has several undesirable consequences: it subjects women to a more interventionist style of practice, it tends to make it more difficult for women outside urban areas to find local caregivers, and it is an inefficient use of expensively trained medical specialists. Both the OMA and CMA have suggested ways of strengthening the general practitioner's presence in obstetrics. These include improving obstetrical training opportunities for interns and family practice residents (particularly to equip them for rural practice), financial assistance to rural hospitals to enable them to provide general practitioner anaesthetic on-call services in support of obstetrical services, continuing education programs aimed at helping practitioners maintain competence in primary obstetrical care, and structured on-call systems to ease the burden of obstetrical practice. The Task Force has become aware of a gap in the provision of obstetrical services in locations served by general practitioners and surgeons, but not by obstetricians. A woman may unexpectedly develop a complication (for example, a breech or posterior presentation) that her general practitioner is unable to deal with. Since no obstetrician is available to conduct the delivery, a surgeon will usually be called to perform a caesarean section. The result is caesarean sections that would not be necessary if physicians with more specialized training were available. Consideration should be given to establishing an enriched obstetrical program for general practitioners to equip them to deal with certain obstetrical complications without resorting to caesarean section.

10. **The defensive style of practice caused by fear of malpractice litigation can be moderated.** The Task Force heard time and time again that the fear of being sued induces physicians to order more tests and diagnostic procedures, influences their decisions whether or not to resort to caesarean section, and has a negative effect on their relationships with patients. The fear of being sued, together with increases in CMPA fees for physicians providing obstetrical care, is driving some general practitioners out of obstetrical practice altogether. Medical organizations have called for reform in tort laws to ease the medical malpractice situation. Apart from these reforms, which are currently being discussed in Ontario, the antidote to defensive practice may be more open communication between physicians and women, informed choice agreements of the type recommended by the AOM, and education programs that inform women of the unavoidable risks of childbirth and prepare them to accept a loss.

11. **The nurse's role in providing family-centred maternity care can be strengthened.** Nurses can be given a voice in setting hospital obstetrical protocols in hospitals and they can be expressly authorized to vary routines to meet individual needs. In the future, some nursing students wishing to specialize in maternal/newborn care will be able to benefit from courses offered in the midwifery education program. Continuing education programs involving midwives can be offered to nurses.

12. **The Ministry of Health can facilitate discussion of "Good Birthing" guidelines and issues in repro-**

ductive care. Members of the Task Force have participated in the planning of the Ministry's conference on birthing, scheduled to take place in October 1987. Such conferences, as well as smaller colloquiums, can play a valuable role in exploring new directions and developing concensus.

We think that implementation of these items could significantly improve the overall system of care at relatively little cost and with little disruption. Their implementation mainly requires a shift in attitude among caregivers and those who administer hospitals, so that making childbirth a rich and satisfying experience in the life of a family is accorded the importance it deserves.

IMPLEMENTATION TIMELINE

Ministry of Health (MOH)

MOH appoints midwifery program Manager

MOH enacts Midwives Act; amends Public Hospitals Act

MOH:
- appoints interim Council of College of Midwives
- develops program approval and funding mechanism for midwifery practices
- establishes home birth registry

College of Midwives:
- develops qualifications and standards of practice
- develops licensing examination

Professional Organization
- arranges liability insurance for members
- develops self-funded insurance program

College of Midwives:
- licenses foreign-trained midwives, graduates of Midwifery Integration Program
- MOH processes applications for program approval and funding for practices

MOH appoints midwives to Council of College of Midwives

MOH establishes mechanisms to evaluate midwifery practices and for human resources planning

MCU appoints midwifery education program Manager

MCU administers tender for university to run education program and Midwifery Integration Program

University:
- develops and administers Midwifery Integration Program
- develops BScM and Diploma program (curriculum, faculty, clinical placement sites)

University admits students to BScM and Diploma program

University liaises with midwifery practice sites for placements and employment opportunities

Midwives graduate from education program

Ministry of Colleges and Universities (MCU)

ACTION CHECKLIST

	ACTION ORIGINATOR			ACTION REQUIRED	
RECOMMENDATION	MOH	MCU	College of Midwives	Legislation	Funding
Scope					
1. The Task Force recommends that Ontario enact a Midwives Act in which the midwife's scope practice is defined consistently with the international definition of midwife.	X	X	X	X	
2. The Task Force recommends that the activities within the midwife's scope of practice relate primarily to the reproductive cycle.	X	X	X	X	
3. The Task Force recommends that provision be made for the delegation of medical acts to midwives.	X		X	X	
4. The Task Force recommends that the governing body for midwifery be vigilant to ensure that delegation of medical acts is used sparingly so that it does not produce more competence with technology at the expense of clinical skills.			X		
5. The Task Force recommends that the standards of practice for midwives incorporate a minimum of two mandatory medical visits during pregnancy. We recommend that the first mandated visit be as early in the pregnancy as possible, and that the second be at 32 to 34 weeks.				X	
6. The Task Force recommends that there be a third optional visit during the course of the pregnancy, at a time considered appropriate by the midwife, the physician involved in the case, or the woman herself. We recommend that additional medical visits, for which there is no actual need, be discouraged.			X		
7. The Task Force recommends that the standards of practice for midwives include criteria for consultations with and referrals to physicians. We recommend that the governing body for midwives prepare these standards of practice in consultation with the College of Physicians and Surgeons of Ontario, the Society of Obstetricians and Gynaecologists of Canada and appropriate experts in the disciplines of medicine and midwifery. The standards should clearly differentiate between consultations for advice, consultations for advice and treatment, and transfers of care.			X		
Framework of Practice					
8. The Task Force recommends that all midwifery practices display characteristics of safe and effective care.	X	X	X	X	

	ACTION ORIGINATOR			ACTION REQUIRED	
	MOH	MCU	College of Midwives	Legislation	Funding
9. The Task Force recommends that midwives work in hospital midwifery services that meet the requirements for safe and effective midwifery practice.	X			X	
10. The Task Force recommends that midwives work in birthing centres that meet the requirements for safe and effective practice.	X			X	
11. The Task Force recommends that the Ministry of Health expand the mandate of the Community Health Centre program to permit Community Health Centres to employ midwives, provided the requirements of safe and effective practice are met.	X			X	
12. The Task Force recommends that midwives work in services sponsored by boards of health that meet the requirements for safe and effective midwifery practice.	X			X	
13. The Task Force recommends that midwives work in private practices that meet the requirements for safe and effective midwifery practice.	X			X	
14. The Task Force recommends that the midwives and physicians work together in practices that meet the requirements for safe and effective midwifery practice.	X			X	
15. The Task Force recommends that no midwife be permitted to practise except in a practice, service, agency or other health facility approved by the Ministry of Health.	X			X	
16. The Task Force recommends that a mechanism be established in the Ministry of Health for approving all institutional and community-based midwifery practices and services. We recommend that proposals to establish such practices and services be evaluated by a designated operational branch, in conjunction with the Women's Health Bureau, of the Ministry and that approval be granted to proposed practices and services that meet the requirements for safe and effective midwifery practice. We recommend that the Ministry be empowered to discontinue or cancel approval if a practice or service fails to provide safe and effective midwifery care after a reasonable opportunity has been provided for it to do so.	X				X
17. The Task Force recommends that the Ministry of Health appoint a member of its staff to assist applicants in preparing and submitting applications for program approval and funding.	X				

	ACTION ORIGINATOR			**ACTION REQUIRED**	
	MOH	MCU	College of Midwives	Legislation	Funding
18. The Task Force recommends that the Ministry of Health provide funding to approved institutional and community-based midwifery practices and services, including those proposed by individual midwives, groups of midwives, multi-disciplinary groups, boards of health, community agencies, physicians, and hospitals. We recommend that funding be provided on the basis of global program-based budgets.	X			X	
19. The Task Force recommends that midwives be prohibited from seeking or obtaining payment for midwifery services directly or indirectly from clients.	X			X	
20. The Task Force recommends that midwives be permitted to charge fees for childbirth education classes.	X				
21. The Task Force recommends that the Ministry of Health be empowered to permit organizations such as unions, voluntary associations, and charitable foundations to provide full or partial funding to approved midwifery practices and services.	X			X	
22. The Task Force recommends that the *Public Hospitals Act* be amended to empower hospitals to pass by-laws providing for the appointment of midwives to hospital staff.	X			X	
23. The Task Force recommends that the *Public Hospitals Act* and the Regulations thereunder be amended to establish the necessary structures and procedures for appointing midwives to the staffs of hospitals.	X			X	
24. The Task Force recommends that liability insurance be mandatory for practising midwives.	X		X	X	
25. The Task Force recommends that midwives, through their professional association, take steps to develop a self-financed insurance program as soon as possible.					
26. The Task Force recommends that the governing body for midwifery prepare a home birth protocol covering assessment of risk and contraindications to home birth. In preparing the protocol the governing body should consult with appropriate professional organizations and authorities.			X		
27. The Task Force recommends that the governing body for midwifery develop a standard of practice and establish a practice advisory service to provide guidance to midwives with regard to the care of women who choose to give birth at home despite contraindications.			X		

	ACTION ORIGINATOR			ACTION REQUIRED	
	MOH	MCU	College of Midwives	Legislation	Funding
28. The Task Force recommends a flying squad network not be created in Ontario to support home births. We recommend that caregivers and parents take responsibility for ensuring that transportation will be available during labour if needed.	X	X			
29. The Task Force recommends that the Ministry of Health establish a home birth registry for the reporting of the mortality and morbidity outcomes of all home births taking place in the province.	X				X
Qualifications					
30. The Task Force recommends that there be multiple routes of entry to midwifery education in Ontario.		X	X		X
31. The Task Force recommends that midwifery education be provided in two integrated streams: • a four-year stream leading to a baccalaureate degree in midwifery, and • for people who have university-level preparation in nursing, a 12 to 18 month stream leading to a diploma in midwifery.		X	X		X
32. The Task Force recommends that the baccalaureate and diploma streams be offered at the same educational institution, and that courses, teaching and clinical faculty, clinical placement sites, and student activities be combined, shared and intermingled.					
33. The Task Force recommends that midwifery education be based at a university.		X		X	X
34. The Task Force recommends that the midwifery program be located at one of Ontario's health sciences centres.		X		X	X
35. The Task Force recommends that the Northern Ontario Distance Education Access Network be used in order to make it possible for parts of the midwifery education program to be taken in Northern Ontario communities.		X			X
36. The Task Force recommends that clinical components of the programs be arranged in community hospitals and suitable primary health care settings in various locations in Ontario.	X	X	X		X
37. The Task Force recommends that the university not restrict admission or give preferential admission to applicants who reside in the geographical area from which it ordinarily draws the majority of its students. We recommend that attention be paid to applicants' home communities in an effort to admit qualified applicants from every part of Ontario.	X				

	ACTION ORIGINATOR			ACTION REQUIRED	
	MOH	MCU	College of Midwives	Legislation	Funding
38. The Task Force recommends that academic courses and clinical placements in the French language be arranged on an individual basis for Francophone students and that all universities cooperate to permit this to be done.		X			X
39. The Task Force recommends that the Ministry of Colleges and Universities select a centre through a competitive tendering process open to all health sciences centres. We recommend that the criteria used in assessing the proposals relate to the recommendations set out in this chapter, including use of the Northern Ontario Distance Education Access Network, use of other universities for French language instruction, use of clinical education sites in hospitals and primary care locations throughout Ontario, and existence of structures for contacts between midwifery, nursing and medical faculties, and students.		X			X
40. The Task Force recommends that selection of students not be based solely on academic achievement and that procedures used include assessment of applicants' personal suitability for midwifery, including their maturity, motivation, resourcefulness, service orientation and ability to relate to others.		X			
41. The Task Force recommends that admission to the baccalaureate program be considered for students who can demonstrate that their life experience (including work, homemaking, childrearing, and volunteer activities) qualifies them for entry.		X			
42. The Task Force recommends that advanced standing and course remission be available to students in the midwifery program.		X			
43. The Task Force recommends that the baccalaureate curriculum be structured to complement the emerging "two plus two" structure of the baccalaureate nursing program. We recommend that humanities, social sciences, basic sciences and health sciences subjects be concentrated in the first two years, and that midwifery practice subjects be concentrated in the second two years. We recommend that where possible courses be shared with students in other health disciplines such as nursing and physiotherapy.		X			
44. The Task Force recommends that courses be shared with students in the third and fourth years of the baccalaureate stream, and that the clinical placements for diploma students be indistinguishable from clinical placements for baccalaureate students (except the latter will require clinical practice in additional areas of nursing skills).		X			

	ACTION ORIGINATOR			ACTION REQUIRED	
	MOH	MCU	College of Midwives	Legislation	Funding
45. The Task Force recommends that community hospitals with Level I and Level II obstetrical services, community health centers, and physicians' offices in various parts of Ontario be used to provide clinical placement sites.	X	X			X
46. The Task Force recommends that the Ministry of Colleges and Universities or the Ministry of Health make funds available to compensate clinical instructors and supervisors of student midwives.	X	X			X
47. The Task Force recommends that the education program actively seek clinical elective opportunities in other jurisdictions and assist students who wish to take advantage of them.		X			X
48. The Task Force recommends that requirements for graduation include numbers of clinical experiences, including examinations, supervision and care of pregnant women, deliveries; postpartum examinations, and newborn examinations. We recommend that the requirements be the same for students in both the diploma and the baccalaureate streams.		X			X
49. The Task Force recommends that special funds be allocated for the establishment of midwifery education programs, and that the amount of start-up funds reflect the costs of curriculum design, faculty requirement, and arrangements for clinical placement and supervision, as well as necessary capital improvements such as additional classroom space. We recommend that adequate operating grants also be made available.	X	X		X	X
Regulation					
50. The Task Force recommends that midwifery be regulated through a system of licensure.	X		X	X	
51. The Task Force recommends that the titles "midwife" and "licensed midwife" and the abbreviation "L.M." be protected titles for the profession of midwifery.			X	X	
52. The Task Force recommends that a new governing body, to be known as the College of Midwives, be established to regulate the profession of midwifery.	X		X	X	X
53. The Task Force recommends that the Lieutenant Governor in Council appoint 13 members to serve on the Council of the College of Midwives at pleasure.	X			X	X
54. The Task Force recommends that representatives be selected from among students in the Midwifery Integration Program and foreign-trained midwives waiting to present their credentials for recognition, to provide liaison and advice to the interim Council.	X		X	X	X

	ACTION ORIGINATOR			ACTION REQUIRED	
	MOH	MCU	College of Midwives	Legislation	Funding
55. The Task Force recommends that three midwives be appointed to the Council as soon as possible, selected from among the midwives licensed after successfully completing the Midwifery Integration Program and foreign-trained midwives whose credentials obtained are recognized. We recommend that the number of places on the Council allocated to midwives increase thereafter by one place every two years, to a maximum two-thirds of the total number of places. We recommend that the midwives appointed to the Council replace representatives of other disciplines rather than consumers.We further recommend that midwives be elected to the Council, rather than appointed, as soon as their numbers warrant.	X		X	X	X
56. The Task Force recommends that in the long run the permanent Council of the College of Midwives be composed of between nine and 15 members elected by licensed midwives; between three and five public members appointed by the Lieutenant Governor in Council; and one person appointed by the university which administers the midwifery education program.	X		X	X	X
57. The Task Force recommends that the Council be required to constitute an Executive Committee, as well as committees responsible for Registration, Fitness to Practise, Continuing Competence Assurance, Complaints, and Discipline.			X	X	X
58. The Task Force recommends that the College of Midwives share administrative services, office facilities and staff with one or more Colleges of unrelated health professions.			X		X
59. The Task Force recommends that the College of Midwives establish criteria for recognizing the qualifications of foreign-educated midwives. We recommend that the criteria relate to the equivalency of educational preparation, and the recency of practice experience.			X		
60. The Task Force recommends that the College of Midwives set and administer an examination for all midwives who wish to be licensed to practise in Ontario.			X		
61. The Task Force recommends that the College of Midwives, through the Continuing Competence Assurance Committee, establish systems for assuring continuing competence.			X		
62. The Task Force recommends that the College of Midwives be empowered to prosecute people who contravene midwifery legislation.	X		X	X	

	ACTION ORIGINATOR			ACTION REQUIRED	
	MOH	MCU	College of Midwives	Legislation	Funding
63. The Task Force recommends that the Ministry of Health subsidize the establishment and ongoing operation of the College of Midwives until the profession has sufficient numbers to bear the full costs of College operations.	X		X	X	X
Integration					
64. The Task Force recommends that a Midwifery Integration Program with the following characteristics be established for the purpose of integrating people into the profession of midwifery.	X	X	X		X
65. The Task Force recommends that the Integration Program be administered by the same educational institution that will administer the basic midwifery education program.					
66. The Task Force recommends that adequate funding be provided to the Midwifery Integration Program by the Ministry of Health and Ministry of Colleges and Universities.	X	X			X
67. The Task Force recommends that the Midwifery Integration Program be offered for a limited time.	X	X			
68. The Task Force recommends that provisional licences not be issued to students in the Midwifery Integration Program to authorize them to practise midwifery outside the Program.	X			X	
Potential Requirement					
69. The Task Force recommends that the Ministry of Health and the Ministry of Colleges and Universities coordinate human resources planning for midwifery, nursing and medicine.	X	X			
70. The Task Force recommends that nursing, medical, and midwifery bodies that address human resources planning in submissions to government consider the role played by the other professions in providing maternal and infant care.	X	X			

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APPENDIX 1

A History of Midwifery in Canada

Introduction

> The practice of midwifery dates back to the beginning of human life. Its history parallels the history of the human race and its function antedates any record we have of medicine as an applied science. To deny its right to exist is to take issue with the eternal verities of life itself. (Charlotte Hanington, Chief Superintendent of the Victorian Order of Nurses, 1923)[1]

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> The name 'midwife' for me carries a certain odium, because I never hear it when it doesn't call to my mind a picture of Sairey Gamp and Betsy Prig, untrained, unkempt, gin soaked harridans unfit for the work they were supposed to do, and a menace to the health of any woman whom they might attend. (William B. Hendry, M.D., Obstetrician, Chairman of the Maternal Mortality Committee of the Canadian Medical Association, 1931)[2]

These two statements give an indication of how long the debate about midwifery has had a place in Canada and are an accurate reflection of how different the positions in the debate were from one another. Charlotte Hanington was speaking to a large assembly of influential women, the delegates to the 1923 annual meeting of the National Council of Women. William Hendry was speaking to an equally large assembly of influential doctors, most of whom were male, at the 1931 annual meeting of the Canadian Medical Association. In these two settings, the views were almost perfectly polarized into their appropriate gender groups.

Of course the two massed polarities never actually met in one place to confront one another. And in some ways the view from outside is rather misleading: in real life, the sides were not so clearly defined. Throughout the history of the debate, midwives had a few loyal and persistent friends in the ranks of Canadian doctors. Conversely, some of the most convinced and effective crusaders for medical childbirth were also members of the National Council of Women.

The story of midwifery in Ontario, and in Canada in general, is the story of a highly developed birth culture, surprisingly similar in both native and settler populations, that was gradually eclipsed by expanding medical control over childbirth. Modern obstetrics seems to have made very little accommodation with the popular birth culture. The guiding principle of obstetrics, as we shall see, was the clean sweep. In order to justify this sweeping motion, it was necessary to promote the view that traditional childbirth was dirty and potentially dangerous. Consequently, mortality figures have always played an important part in the midwifery debate. This appendix will examine the relevant mortality data of this century. There is a caution to the reader, however, not to take these figures too seriously—even the ones that seem to prove conclusively that midwifery was far safer than medical birth. Childbirth mortality data have a history of being somewhat inaccurate. In the area of perinatal mortality, it was the custom until the late 1930s to present only "infant mortality." Since this category refers to deaths under one year, it is rather general, and not very useful in an examination of birth outcome. There were also many problems around birth registration, leading initially to an artificial inflation of infant mortality and later to an exaggeration in the curve of the fall.

Another problem is that infant mortality was affected by societal attitudes that have now faded, but which until at least the 1920s led to the demise of many "illegitimate" babies in this manner:

> ...it is accepted as the belief that the kindest thing is to baptize these children and then facilitate their exit from this world as much as possible. The practice both amongst Roman Catholics and Protestants has been to take such children to the Grey Nuns and to hand them over with a sum of $10 to be provided for as best they might. The babies are farmed out with the result, according to their own showing, that the number of deaths amongst such children in some years has been as high as 90%, and one year actually 99%.[3]

Numerous references to this practice suggest that infant mortality figures were considerably expanded by it. The additional factor of the rising popularity of bottle feeding, which led to anomalies such as a higher death rate of babies in sewered parts of cities (where the better-off, more modern, bottle-feeding mothers lived) compared to the poor, unsewered sections (where the poorly-educated, often immigrant, breast-feeding mothers lived), so confound the evaluation of infant mortality data that we will not try to use them in this appendix.

Maternal mortality figures, although clearly related to birth outcome, were also somewhat unreliable. Mortality data were distorted by mistakes in filling out death certificates, doctors' desire to cover up deaths related to faulty technique, reformers' attempts (including those wishing to promote midwifery) to goad the government into funding new programs, and inconsistencies in the definitions used in vital statistics legislation. It is possible in some cases to go over the original data and try to reanalyze them in order to answer questions about the comparative safety of midwives and doctors. Sometimes the new analysis is suggestive, but many more times we have to accept that the figures we need were never gathered and that some questions, therefore, will never be answered. It is quite helpful, however, to note which data led to further examination and which were just filed away.

One thing that is clear from many different mortality surveys, as we will see, is that the progression from the popular birth culture to modern obstetrics took place during a time when, for more than three decades, medical birth in hospital was statistically more dangerous than birth accomplished at home in the traditional manner. The popular notion that midwives yielded to modern obstetrics because it was shown to be safer is therefore in error.

How was it possible for a relatively small number of people committed to medical hegemony over childbirth to erase a birth culture that, as Charlotte Hanington asserted, had endured since the beginning of time—and which was still an intimate part of the fabric of community life in all parts of Canada at the turn of this century? It is sometimes asserted that it was the supposed illiteracy of midwives, as well as their political naiveté, that led to their defeat. But this supposes that midwives were in fact a group who could be corralled and led away. This notion gives an inaccurate view of the birth culture. As we shall see, in most communities across Canada where birth was not handled by a doctor, women helped one another. In much of the country, birth was regarded as an event that was central to the life of the community, intimately a part of women's culture — and midwifery was thus rarely a trade or a profession in any sense that was parallel to the professional ambitions of doctors. To ask why the midwives were not able to form themselves into an enduring profession in Canada, then, is to ask the wrong question. It is not that midwives — those many neighbour women who helped one another in childbirth — lacked the imagination or the energy to build a profession that could challenge the doctors. It is that their imagination, and their culture, gave them a different vision. This vision held that childbirth belonged to the community, and was rarely a career. In the context of the traditional birth culture, an organized movement to shape childbirth into a medical event required working across a broad front, as we will see, to alter the vision with which whole communities saw childbirth.

This appendix examines the popular birth culture and the rather complex reasons for its disappearance.

Early European Settlement

The earliest mention of midwifery among non-native women in Canada appears in a deed in the Montreal Archives, which reveals that "the women of Ville-Marie, in solemn conclave assembled, on February 12, 1713 elected a midwife, Catherine Guertin, for the community."[4] Midwives in New France seem to have been trained in France and paid by the French king: in 1722, for example, a midwife called Madame Bouchette received payment from the King of 400 livres for her work for the year.

In the English settlement of Lunenburg, Nova Scotia, Col. Sutherland, the commander, wrote to the British government in 1755, asking that two midwives be paid two pounds a year.[5] In 1764 the allowance for the midwives was eliminated by the British,[6] but that of the midwives of New France seems to have been raised at intervals until the British takeover.

No record has been found of the birth mortality of women delivered by these early midwives. It would be a mistake to assume the mortality was high. In similar circumstances in Rhode Island, during that time, a reckoning of mortality was made by the Rev. Ezra Stiles, president of Yale College. He calculated that between 1760 and 1764, when approximately 600 women bore nearly 1600 children, only 10 women died in childbed.[7] This rate is as good as that which existed generally in the U.S. and Canada in the 1930s.

There is no other region in Canada where midwives were on government salary. Indeed, as we move west from Montreal, there were few doctors before the 1830s and no full-time midwives at all. Nor does it seem that the earliest European settlers missed having someone especially designated to look after their ills or their births. Robert Gourlay, a contemporary chronicler of the opinions of the settlers, published the results of questionnaires he sent out to all the settled areas around York and Niagara in 1806. He reported that most of the districts denied wanting a doctor in their area: "We have hitherto been blessed with so healthy a climate, as to require little or no aid from medical men, the consequence, therefore, is, that there is none in the parish, the nearest to us being 6 miles, whose practice is none too lucrative from the country twelve miles round."[8]

Where settlement was new and spread out, and doctors and midwives few, most ordinary people seem to have been confident about what to do at a birth. We learn, for example, from Mary O'Brien, who lived near what is now Barrie and who kept a journal from 1828 to 1838, that her husband was her most important assistant at the birth of her daughter.

> It was with more cheerfulness than awe that, with occasional interruptions and the assistance of the damsel [servant] I arranged my bed... I was secretly rejoicing in the probability of being beforehand with the doctor. I then methodically, with Edward's assistance, undressed and prepared myself. I placed everything likely to be wanted within reach... In about ten minutes after, and almost as soon as I became assured that the crisis of my complaint was actually coming on, the little damsel was in her father's hands, audibly existent. In two minutes more she was lying snugly in my arms till the conclusion of our operations should give us leisure to attend to her further needs.[9]

The placenta was slow in coming, but was delivered after an hour, during which the baby spent her time nursing at her mother's breast. When everything was done, the doctor arrived "to congratulate us, eat his supper and go to bed." This was Mary O'Brien's third child. She had had a doctor at the births of the first two, but seems to have felt no need of one from then on. A month afterwards, she was called to help another woman.

> Nov. 15—A fine day. I was arranging to pay a visit to go to the shanties when I was sent for to the assistance of one of our labourers' wives on the wharf. I packed up my baby in the arms of my damsel whom I needed as interpreter and, leaving the other two with Edward, I hastened away. I arrived just in time to do the needful for a fine little girl. This is the second time I have cheated the doctor within four weeks. The said doctor arrived just after the work was done to look very foolish and go home with me to dine (said doctor not being the same whom I cheated before). He is a young Scotsman lately come out. Doctors have no chance at such work here. We make so light of it.[10]

Although Mary O'Brien, and most of the earliest settlers in Ontario, came from a country where doctors had already come to be regarded as appropriate birth attendants by the middle class, they adapted themselves very quickly to the needs of their new situation and recast their birth culture to one of family and neighbour involvement. The sharing of the birth event may have had crucially important benefits, both in strengthening family bonds and in establishing emotional links between groups of randomly assembled, often homesick, strangers as they began to form their new communities.

The Native Birth Culture

The indigenous birth culture in Canada was similar in some respects to the one the European settlers were to develop. Among the various Indian and Inuit tribes in the different regions, birth customs varied according to whether there were settled communities or nomadic tribes, small groups of several families travelling together or large, politically complex nations. In general it seems that birth knowledge was widespread and attitudes toward birth hopeful rather than fearful. In 1830, in her travels throughout Upper Canada, Anna Jameson wrote that birth was "in general a very easy matter among the Indian women, cases of danger or death being exceedingly rare...."[11] A physician reminiscing about the natives of the Maritimes reported that:

> The Indian women were well built, lived an outdoor life, were healthy, strong, very patient, and bore children well, a very large proportion of whom were normal. She [sic] walked or stood up until the last stage of labour. Delivery took place while the woman was squatting on her knees or her hands and knees or elbows, only occasionally lying down. She might hold on to an attendant, usually another woman, or a sash, strap, or stick which was fastened nearby for the purpose. Pressure was made on the abdomen by kneading with the hands or with a binder. After birth the perineum was washed. She rested one day and was up on the second day.[12]

Although most communities seem to have had a number of women recognized as midwives, the seasonal migrations of the largely hunter-gatherer societies meant birth knowledge had to be widespread in the community. If a problem arose out on the trail, it might have to be dealt with by the husband alone. Anna Jameson tells of such a situation.

> Mrs. Schoolcraft told me of a young Chippewan who went on a hunting expedition with his wife only; they were encamped at a considerable distance from the village, when the woman was seized with the pains of childbirth.... On this occasion some unusual and horrible difficulty occurred. The husband, who was described to me as an affectionate, gentle spirited man, much attached to his wife, did his best to assist her; but after a few struggles she became insensible, and lay, as he supposed, dead. He took out his knife, and with astonishing presence of mind, performed on his wife the Caesarean operation, saved his infant, and ultimately the mother, and brought them both home on a sleigh to his village at the Sault, where, as Mrs. Schoolcraft told me, she had frequently seen both the man and the woman.[13]

Nurse-midwives and physicians working with Indian and Inuit people during the last three decades speak respectfully of the knowledge of anatomy and physiology possessed by native midwives. It may be that the familiarity with animals in a hunting society led to confidence and ease about the physiology of birth. They have also noted the relative lack of complications accompanying births. Difficulties resulting from disproportion seem to have been very rare possibly because native babies tend to be smaller than non-native, weighing about six and a half pounds on average.[14] Certain other problems seem to have been peculiar to only some of the native groups. Among the Inuit tribes of certain regions, retained placenta was a common difficulty leading to postpartum haemorrhage. Native midwives learned, perhaps over generations or even centuries, how to deal with this problem by prompt removal of the adherent placenta. Although they used their bare hand to scrape the inside of the uterus, infection seems to have been rare.[15]

Missionaries who did medical work while proselytizing among the Indians were frequently disparaging in their comments on native healing skills, but even they commented on the very low infection rates. Dr. George Darby, a long-time medical missionary in northern B.C., gave this description at a meeting of his medical association in 1931:

> While some of the native midwives attempt to extract the baby in delayed cases, they have no instruments except their fingers, and I do not think they accomplish very much. As a rule, there is no interference, and though the bedding and bed may be very dirty, there is rarely any infection. Usually the room is darkened, if a women is sick in the daytime, and a dimly lighted lamp is placed in a far corner. Three or four old women sit on either side of the patient who is usually on a mattress on the floor. They support the patient, help her to change her position, and utter occasional words of encouragement. On the whole, there is very little said and the silence and darkness make it a very solemn occasion. When I am called and find on external examination that the case is proceeding normally, I leave it to the women, though I sometimes wait to see what happens. One day, as soon as the baby was born, one of the attending women picked up a pair of scissors from the floor, walked to the window, tore a strip from the cotton rag that was serving as a sash curtain, tied the cord with it and cut it with the dirty scissors. I was so amazed that I couldn't interfere. However, both the mother and the baby got along well.[16]

When medical missionaries were replaced by government medical workers, who had a less urgent interest in abolishing the native culture, the new arrivals seem to have been more impressed with the skills of native midwives than was Dr. Darby. Both the persistent occiput posterior position (the baby is born face up and with its back towards the mother's back — this presents a wider diameter and the usual processes of flexion and extension are altered), common among some Indian tribes, and breech births (feet first rather than head first), seem to have been handled confidently and well by native midwives. Rita Dozois, a nurse who worked in Northern Ontario and Manitoba during the 1950s, reported that the potency of native herbal remedies was common knowledge among Medical Services nurses.

> They had a lot of herbs that they used, and I think that some of them are as good if not better than our drugs. I know that they have a herb to certainly stop postpartum haemorrhage in most of the reserves, and I know that one of the midwives, a British trained midwife, maintains that she was losing this patient, the woman was just haemorrhaging to death and she couldn't do anything to stop it. With all the medications that she was giving her, there was just nothing touching her. And this one medicine woman brewed up a tea and gave it to her, and within half an hour, the bleeding had stopped and her blood pressure started to go up again. This British midwife said to me, "I know that I was losing her, there was just no question about it." And so they did have these medicines that they used... and they still use them.[17]

The importance of each birth to the whole community emerges from virtually all reports of native birth customs. Among the Inuit, the role of the woman who first received the baby was central and would lead to a lifelong relationship between this woman and the child.

> In the native midwifery amongst the Inuit, one lady would deliver the mother, a second one would take the baby just as soon as it was delivered and separate the cord and do all the things needful for the baby while the other midwife looked after the mother. Now that second midwife, who was referred to as the cineretok, would then always have a special relationship with that baby. It would start right at the time of birth. The first thing that the baby grabbed of the mother's when the child was cradled in the mother's arms, quite often it would be perhaps a sweater she was wearing or something, that would be given to the cineretok. Then the cineretok would bring or make for the newborn baby a small pair of deerhide or moosehide slippers, baby size. And on through life there would be the exchange of these gifts. The relationship between the child and the cineretok would go on for years, well for always, something in a way like our godmother's sort of relationship. And as the child grew older, she or he would be perhaps carrying water or bringing in wood for the cineretok. And in a way, what it's doing is building up special kinship relationships, because, if for example, the cineretok or some of the midwives might be widowed or without children of their own, then they would be able to have kinship through this birth that would assist them with life's problems as the years went by.[18]

This story implies that attendance at births was not limited to the same few women at every birth. It seems to have been true in both the Inuit and native Indian cultures that, while there were a few women who were recognized as the senior and most experienced midwives in the group, most of the women in the tribe or settlement also went to births from time to time. Not only was birth knowledge shared around, but also were the benefits of the status of birth-helper.

The participation of men varied, apparently according to how likely it was that they would have to help their wives on their own some day. In established villages the men might withdraw from the birth room, but keep themselves near enough to be summoned if anything was needed. In Inuit society, on the other hand, even men unrelated to the birth mother were often required to take an active role at a birth. There is a carving at the University of Manitoba which its donor, Dr. Otto Schaefer, describes as follows:

> The husband, his wife, knee-elbow position in the last stage of delivery, baby's head just appearing between her legs. The husband has his hands on the fundus of the

> uterus, pulling down. I guess the woman was a little bit in difficulty — she felt, or they felt that the second stage was a little bit delayed, and wanted to hasten it on — so the father, standing behind the knee-elbow positioned woman, is pulling down. To balance that pull, there are two young men who are going to be married the next year or so, pulling the arms of that woman forward. Underneath as a support of her chest, there is an older woman, kneeling. A moment later — I have seen it myself, those deliveries — she will jump out and take the place of the husband, and there she develops fully the delivery of the head and shoulders of the baby. This was a *group* carving — it was a group experience. The husband often had to do it, and in order for the young fellows there, 17 or 18 years old, to be married in the next few years — in case their wife had to be delivered on the trail, and there was nobody around, they had to gain knowledge of it, and so they were there.
>
> There were several other women around, stroking the woman who was in pain, admonishing her, or singing a little low song to her—so it was a whole community affair.[19]

Native birth culture in its regional variations, presumably having endured for many centuries before the various native groups had contact with Europeans, has even yet not quite died out, despite drastic interventions by non-native medical workers wherever contact was made. The parallel birth culture developed by the early European settlers, on the other hand, has vanished so completely that most people in Ontario are unaware that one ever existed. The flowering and subsiding of our pioneer birth culture happened over a period of a little over one hundred years. Until recently, little has been written about this birth culture. By going through settlers' accounts in archives, through autobiographies, through older medical journals, and interviewing older people with long memories, it is possible to put together a quite detailed description of how they handled birth.

Development of the Neighbour Network

In Nova Scotia and Quebec, with their long history of midwifery, the practice was legal until after the First World War. In Montreal in the 1870s, midwives were in fact doing most of the instructing of the senior medical students at McGill's Lying-In Hospital.[20] Newfoundland, although not explicitly permitting midwifery, had such a long tradition of it in the villages and outposts that women were in active practice all over that province until the 1960s.[21] Certain more or less homogeneous cultural groups, such as the Mennonites in Manitoba[22] and the Japanese community[23] in the Lower Mainland of B.C., brought experienced midwives with them when they first arrived, and these midwives were recognized and used by their own communities, carrying on the birth customs of their country of origin.

For the most part, though, all through Ontario and the West, women whose primary function was midwifery were rare. Helping out at births was something that neighbours did for one another. There was often a woman with extra skill and experience, who might be especially sought out when a woman was in labour, but these special women rarely did more than 60 to 90 births during their lifetime. They were always women who were themselves mothers. Sometimes they owned fat medical books[24] in which they could look up instructions if they needed to. Some had brought seeds from their home country and planted medicinal herb gardens. Their primary function was running their own households, however, and in rural areas that meant they were very occupied indeed. Their training thus consisted not of years of study and apprenticeship but of their participation in a culture in which most adult women were expected to help one another at the time of birth.

It was possible, in days before birth control, for a woman to begin her learning as a teenager when she was pulled into service for the birth of her own mother's last child. Since children were generally excluded from the birth room, such an event would occur only if the family was isolated by distance or by bad weather, making neighbour helpers unavailable. A girl's first teacher in "what to do" would then be her own mother.

> Cutting the cord. That was the part that really bothered me. I felt for sure that the cord was connected with my mother. That was before the placenta came and I didn't know that there was more to come. My mother hadn't told me that. So she said: "You have to cut that. It won't hurt me, you know, it won't hurt anybody, because it's a thing apart from both me and the baby." And you know, cutting that it's just like cutting a finger. It's tough, it's a real tough muscle. We had scissors, probably not that sharp. She said: "We can get Dad to cut that if you don't like doing it." But I said I'd do it. If there was something to do, I'd do it.[25]

The participation of husbands seems to have varied from one region to another. In general, if the birth was taking place in an established community with farms close together and a developed network of neighbour women to help, the husbands did not participate directly in the birth, although they usually stayed close by and helped if they were needed to get another person. If the farm was in a more isolated area, or if the weather was very bad, the husband would himself act as his wife's birth assistant, sometimes her only one.

Of course, if the house was far from neighbours and the husband had to go trapping or hunting, it was entirely possible, and not uncommon, for the woman to be quite alone when she went into labour. Here is an excerpt from a letter preserved in the files of the Maternal Welfare Council, the letter originating in Big River, Northern Ontario:

> I am pleased to tell you that everything went well, I had a fine strong 7½ lb. boy on Oct. 21 who weighed 10½ lb. on Monday last, 7 weeks old... [When he was born] I was quite alone except for two sleeping children, and was able to wash and dress Sonny myself, not to mention lighting the fire, getting hot water, etc. Surely God helps those who help themselves.[26]

Such a situation does not seem to have been regarded as desirable. Whenever possible, women were joined by female neighbours and relatives when they gave birth. There is little mention of special techniques used by these women as they helped one another. Like their native Indian and Inuit counterparts, they seem to have interfered very little. The one main, overriding rule seems to have been to stay with the mother throughout the whole of her labour, to comfort her, and never to leave her by herself.

> I mean, we didn't know exactly when a baby was going to be born, but when you were there, you just didn't feel like leaving. The mother was more reassured when you were with them, you know. And you weren't always doing a lot of work all the hours previous to the birth of the child, but you were doing anything you could to allay fears, perhaps for a young mother with her first child. They had to be comforted. And you know, just the little things — if you only rub their back a bit or things like that, they'd help a bit, you see?[27]

Position in labour varied. Most women tried to walk around and keep to their activities as long as possible during the first part of their labour. Squatting seems to have been common during the pushing stage. There is seldom mention of the boiling of instruments or the preparing of sterile cloths until the 1940s. The theories of Semmelweis and Lister about invisible contamination found little application in the popular birth culture. It was seen as important to keep clean, however. Some women made themselves a little mattress of "the cleanest straw" and delivered their baby onto that. It appears that infection rates were very low in rural areas.[28] Urban poor areas where midwives practised, for example in Halifax or Montreal, may have had more difficulty with postpartum infection. There is evidence, however, that "milk leg" fever, as it was popularly called, was less likely to be fatal in home than in hospital births until the end of the 1930s.[29]

The material aid given to the household by the neighbour women was seen as being just as important as the supportive circle at the time of birth. Virtually all accounts mention baby clothes or quilts or meals made during the time the woman was in labour and help given afterwards in the barn and with the housework.

> Female relatives were usually always about, and also neighbouring women. They would wait with the midwife in the kitchen while the woman was in labour, and often they would have what in Newfoundland they call 'bees' or 'frolics' which would be like spinning bees or knitting bees. And what it would mean is just that four or five women plus the midwife would be knitting baby clothes or something for the women — something special, probably for when the baby was born. Or maybe they would make a quilt. And they would just pass away the time that way. One or two of the women would clean the house for the mother, because the lying-in period usually was around 11 days. So some neighbour women would take care of cleaning, others would cook the meals. So they all took part, and women would come and go, and the grandmother usually was always there. She had a sort of special status. It was really a female event.[30]

It was the custom in all but the most isolated areas to insist on 3 to 10 days' rest for the new mother during which time she might get up to the bathroom or to take meals with the family, but must otherwise stay in bed to "let everything settle back into place." At a time when the workload of the farm woman extended from before dawn to late evening, such a break must have been spiritually as well as physically profoundly helpful. The women who waited on the mother during this time, coming from the same situation, would most likely have been skilled at giving the help that was needed. Many seem to have travelled back and forth between the home of the new mother and their own homes, where work still needed to be done. If a project was underway when the call came that a woman was in labour, the project might have to be brought along.

> I recall one time a man coming 18 miles in a sleigh to take my grandmother to his wife who was expecting a baby. My grandmother had mixed bread dough earlier in the day, so she packed the pan of dough in with her in this sleigh, which was comfortably warm with lots of blankets and quilts and heated stones. When she arrived at the farmer's home the dough had risen enough to bake, so she baked it in the stove in his kitchen, and after she delivered the baby, the husband drove my grandmother back home with all her bread baked.[31]

So the baby was born and the bread was done. Having a baby, while it was seen as a very special occasion, did not involve a radical break from the business of daily life. Even the trained nurses who later on came to work in outpost communities seem to have soon left out much of the bustling and sterilizing and graphing that they had been taught at nursing school. The event of birth was so securely entwined with the other work of women — the preparation of food, the manufacturing of clothing, the maintaining of the home — that the nurses might find themselves pulled into the female activities surrounding the birth. Here is an account by nurse Myra Bennett of a birth she attended in Labrador.

> I remember on one occasion I was attending a maternity case some miles away from home. It was a first baby and didn't seem to be in a particular hurry to arrive. Everything was normal but we didn't feel right about going to bed, when the patient was experiencing discomfort, so we got to work.... The father-in-law was a fisherman who needed new mitts, so out came the bag of wool.... As soon as the yarn was ready, one of the younger girls commenced to knit the mitts, and during that night of waiting, a brand new pair of mittens were completed for the thankful father.
>
> In between the spinning and completing of the mitts I had set to work cooking up a huge pot of stew. We prepared fresh rabbits, some salt beef, all the vegetables obtainable... and these were cooked together until they were almost tender enough to fall apart. It was an absolutely delicious stew.... The patient commenced the more urgent stage of her labour well fortified with this meal, and we who attended her had a very satisfactory night which ended in the morning with the arrival of a perfectly beautiful baby.[52]

Although it was regarded as very acceptable to summon any woman who was available when a woman was in labour, it seems to have been unheard of except in the most isolated, frontier areas that the woman who came to help would be a stranger to the mother giving birth. A primary characteristic of the popular birth culture that flourished in Ontario and other parts of Canada until after the First World War was that the birthing woman was surrounded by other women she knew, who shared her life and fate and status in most respects and who expected to fit themselves to the needs of the new baby's family rather than to impose any medical structure on the event. It appears that money was seldom exchanged for this kind of help. "Turnabout" help was the labour that tied the new communities together and enabled them to be built up from nothing in a relatively short time. Help at birth times would generally be repaid with produce or with help with farm work, house raising, or birthing attendance at a different house the next season.

The First Mortality Surveys

Witnesses and chroniclers of the time usually mention that the general health of women was good: "women in them days, they worked hard and it didn't bother them any."[53] This may have been one explanation of why the few maternal mortality studies investigating medically unserviced areas in Canada from 1918 onwards startled the investigators by their superior outcomes. Dr. M. Seymour, Medical Officer of Health for Saskatchewan, reported at a Maternal Health Committee meeting in 1919 that the 50% of the province's women who gave birth without either doctor or nurse attending had a "much lower" maternal mortality than the other half. He was taken to task by his colleagues for even compiling the figures although, as he pointed out, he had taken care to ensure that the figures would not be given to the public.[54] Similarly, the Minister of Health for Manitoba, Dr. E. W. Montgomery, reported in an article written in 1930 that during the period from 1921 to 1927, maternal mortality all over Manitoba was three times as high in hospital as in non-hospital births. When only non-hospitalized cases were considered, the highest mortality "occurred in one of the most thickly populated and medically best served districts in the province, while the lowest rates recorded were of a municipality and an unorganized district where the population is scant and there is neither a resident doctor nor a public health nurse".[55]

Inexplicably, Dr. Montgomery concluded his article by stating that the absence of medical service in unorganized districts "no doubt contributes largely to the high maternal mortality rate."

In Ontario in 1928, an Ontario Red Cross investigation sought statistical evidence of the advantage of having Red Cross Outpost Hospitals in isolated areas; it came up with the disappointing information that maternal mortality in Red Cross Hospitals was higher than in medically unserviced areas. In fact, when maternal mortality figures of five large unserviced areas were averaged, they were lower than maternal mortality for Ontario as a whole (4.3/1000 versus 5.6/1000).[56]

When confronted with these figures, Dr. Fred Routley, the Director of the Ontario Red Cross, had a similar response as did Dr. Montgomery to his situation in Manitoba.

> The ordinary perusal of the results of maternal mortality in all hospitals, as compared with the general maternal mortality throughout the country, never looks favourable to the hospitals as it is quite generally known that such mortality is much higher in hospital than out of hospital. The reasons for these results are probably not apparent to the ordinary observer and I am satisfied that if every case of maternity in Canada were conducted in hospital, our general maternal mortality rate would be much lower than it now is.[57]

It is easy to see that even at the time when the popular birth culture was highly developed, particularly in the undoctored frontier areas of this country, there was a strong belief in the superiority of medical birth, especially on the part of investigators with a medical education. Statistical results that tended to point away from doctor-led births did not lead to further investigations. The proponents of more extensive medical involvement in birth had no interest in documenting the positive attributes of the popular birth culture.

On the other hand, when they were focussing on their own corner of the vineyard, proponents of modern obstetrics were not shy about denouncing those physicians whom they felt gave their profession a bad name. Here, for example, is an editorial published by the *Canada Lancet* in 1885, entitled "Meddlesome Midwifery," which draws a clear line between "scientific" and "unscientific" obstetrics:

> The representative of the latter class, fully conscious of his lack of skill, but desirous of earning his fee and making a show, at once removes his boots and takes up a position on the bed or the couch, where he holds the fort until the agony is over. His digit finds its way into the vagina, now correcting this, and again that, and with groans and grimaces tugs away, until at last by his herculean efforts delivery is accomplished. But his work is not yet completed. The afterbirth is grown fast to the side and must be removed. A few pulls at the cord, a rude introduction of the hand, and this is accomplished. Nothing now remains but to pompously claim credit for conducting a bad case to a successful and happy issue, and to retire, covered with glory. This is no overdrawn picture, but a true representation of what is enacted in many cases every day, even in Canada, where the profession is fully up to the average, both as regards character and skill. Were this serio-comic performance a mere sham, devoid of positive harm to the patient, however degrading to the performer, it might be dismissed with a few words. But such is not the case. Constant manipulation of the soft parts causes a dryness and irritation painful to endure, to say nothing of the increased danger of introducing septic matter. Nor is this all. One of the tricks of these meddlers is the introduction of the finger within the os, at each pain, for the purpose of dilatation. The cervix is probably more frequently lacerated from this cause than from the passage of the child. Such meddlesomeness is harmful, exceedingly indelicate, and in all respects, most reprehensible."[18]

The Popular Birth Culture: Its Remedies for Problem Births

Assuming this kind of "meddlesome midwifery" was indeed "enacted in many cases every day" and considering the kinds of obstetrical innovations that came into vogue after the turn of the century, we might conclude that the superior outcome of births without professional attendance was the result of a relative lack of interference. This does not mean, however, that the main positive attribute of the popular birth culture was the tendency of birth helpers to stand by and do nothing. In fact evidence to the contrary is recorded in pioneer accounts of births in which there was a crisis.

Here for example is an account by a country doctor of the first time he encountered the practice of "quilling." He had been called because of a labour that was not progressing and had found that despite an injection of codeine to relax the labouring woman's cervix, she seemed to be making no progress. The midwife who was present suggested that they ought to "quill" the woman, and the doctor, not wishing to show his ignorance of what exactly this meant, finally encouraged the midwife to go ahead.

> She immediately got up from her chair and pulled down the wing of a goose which was hanging on a nail behind the stove. She got a nice long goose quill (a waivie one it was) and cleaned the inside of the quill, cutting off both ends. She went to the cupboard and dipped one end of the quill into a small package of cayenne pepper. I wondered what the devil was coming next, so I followed her into the bedroom. She took the quill and inserted it into the nostril of the patient, then gave it one big blow, and away went the cayenne pepper into the poor woman's nasal cavity. I knew what was liable to happen. She began to sneeze immediately. With the sneezing the midwife said, "Doc, you'd better get ready."
>
> By the time I had taken a look at things, the perineum was bulging, and with another few sneezes, the baby was born.
>
> The midwife made only this remark, "I knew, Doc, that this would make her let go her 'holt'." I have never forgotten this way of conducting a quick labour."[19]

The story told previously by Nurse Myra Bennett, about the rabbit stew that fortified a woman whose labour was slow, illustrates a more gentle folk remedy for a mother who might be running out of energy during her labour. The significance of the preparation of food, its value not only as sustenance but also as a loving gift from one person to another, seems to have been understood and used often in the popular birth culture. When doctors and nurses first came to work with the people of the isolated areas, they sometimes adapted this humble technique. Nurse Jo Lutley tells how she learned about the therapeutic value of food from another physician.

> When I went to the Grenfell Mission on the Labrador coast, I was told how Dr. Grenfell, when he went up the coast and was called in to do a delivery, and it took a long time, and the mother seemed to be getting tired and they didn't seem to be getting anywhere, he would say "Ah, well, I think I'll cook you up something to eat." And he'd perhaps get out some eggs and bacon. In those days, in many of the homes he went into, that would have been a great luxury. And so he would start cooking that up for the mother. And the story goes that more often than not, before he had finished cooking it in readiness for her, maybe the good smells of it or something, she would go into active labour and deliver. And so I've always sort of gone on that same kind of thing, although I haven't necessarily given people something to eat, I have said, you know, what would you like to eat as soon as we've

> got this job done? And we would sort of talk something like that, and quite often I'd find that that would work just as well.[40]

Such remedies, although gentle, were active responses to a potential crisis. In the case of a dire emergency, such as a woman in convulsions with eclampsia, more vigorous measures were employed. Treatments mentioned in early accounts included hot water compresses, bleeding, and rubbing the woman all over with wet towels. The factor common to all accounts was the constant, assiduous attention paid to the mother. Here is a story told by a Saskatchewan woman named Mrs. Alexena Marion, who was called out during a winter storm to minister to a neighbour woman, apparently dying in childbirth. When she arrived at the house she was taken to the woman's room.

> There was Elizabeth, stretched out on the bed, stiff as a board. I couldn't feel her pulse or heartbeat or anything. She just looked dead. I started rubbing her limbs and back. I rubbed and rubbed until I was at the point of giving up, when she opened her eyes and said a few words. Then she fell back into a swoon. This kept up for hours, but I never stopped working on her. She would come to for a few moments, the pains would come on, she would go into convulsions and her lower limbs would turn up under her, then stiffen up into a dead faint again and so along. Then all at once, she became awake and she spoke a few words. She cried, "I feel something on my leg!" I told Mabel to see what was wrong with her leg. "It's the head," she cried. I said, "Elizabeth don't you dare die or faint. I don't know what I'll do to you if you go into a faint. Keep awake and help yourself and I'll have that baby away for you." In a few minutes, I had finished. A nice, big boy. I told Mabel to take the babe away and to stop her bawling. I had to tend to the mother, who'd gone back to her fainting. Then she came to long enough to finish the rest of the work. I was beginning to lose hope of her recovery when she opened her eyes and asked about the baby. She was glad it was a boy. She said she felt much better and was sure she was not going to faint. She refused to eat, but drank hot tea and went to sleep. Mabel and I sure had a celebration and rejoiced over our great success.[41]

The only certain remedy for the life-threatening condition called eclampsia is the delivery of the baby. Did the birth lore in Mrs. Marion's area specify that constant skin stimulation would promote the continuation of effective contractions despite the mother's state, thereby hurrying the baby's delivery? Was this Mrs. Marion's attempt to rouse Elizabeth from her seizures, to maintain, through constant touch, Elizabeth's slender connection with life? Mrs. Marion's account doesn't explain her theories about the actions she took. Whatever they were, she did end up with a live mother and a live baby.

In addition to the active measures that were practised by the popular birth culture in times of trouble, there were also prenatal customs that would have tended to promote successful pregnancy. Folk wisdom specified that pregnant women must have plenty of good food, and that the woman who kept active in her normal household tasks would have an easier time giving birth. Several generations of women were to pass through severe calorie restrictions as well as reduced physical activity, advised by their obstetricians, before the good counsel of the original folk wisdom was to regain ascendency.

Weaknesses of the Popular Birth Culture

Counterbalancing the resources of the popular birth culture was the fact that in some frontier areas women and their husbands arrived so unprepared, both in their farming and their birth knowledge, that a half-starved, thoroughly confused woman might end up facing labour alone, while her husband desperately rode around the countryside searching for some other human being to help out.

> In one case that I personally know of the husband drove 40 miles for the nurse. Returning with her, he found the river had risen. They were obliged to camp under the wagon for 24 hours on the river's bank. When they reached their destination they found the mother very sick, with a dead baby beside her.[42]

Another problem was the confusion and lack of confidence that sometimes resulted when settlers tried to transplant the medical routines that had been performed by their doctor back home to the wilderness. Here is another of Mrs. Marion's stories, involving Mabel, the servant, pressed into service as an unwilling midwife at Elizabeth's previous birth.

> As the supreme moment had come, Elizabeth called to Mabel to come with the scissors. She ran to her bedroom and locked the door, screaming and yelling. Elizabeth could not reach the scissors on the table, so she got out of bed as best she could and used the scissors, and fell back unconscious on the pillows. The husband and midwife [he had gone to fetch a midwife from another part of the county] came into the room and saw Elizabeth covered with blood on her pillow. The midwife thought that the husband had murdered his wife and come for her. She, too, fainted. Walter, the husband, got Mabel to come out and help with the two helpless women, and had to find another lady to finish the job.[43]

Elizabeth was evidently under the impression that it was vital to cut the cord immediately, even before the placenta was delivered. Perhaps she had learned this ritual, imperfectly, from her doctor back home. The simple style of birthing described at the beginning of this paper by Mary O'Brien, with the husband and wife remaining together and calmly dealing with each stage as it came, is replaced by the scene of confused, panicky adults who were perhaps uncomfortably aware from their previous medical experiences and their imperfectly understood medical books, that there were some procedures that they ought to do as the doctor had done, but whose order or meaning they did not necessarily understand. Confidence and optimism were here replaced by confusion and insecurity.

There are also reports in the medical literature of 'barbarous acts' by midwives,[14] usually involving the dismemberment of a wedged baby, and less often, haemorrhage caused by the use of force in extracting the placenta. Although some of these accounts were evidently attempts to discredit all midwives, some others were certainly examples of real incompetence and active damage done to a mother or baby. Perhaps because such damage resulted from the incompetence of individual midwives, rather than from obstetrical vogues practised on large numbers of women, our evidence suggests that the popular birth culture of the early communities was on the whole very successful in the context of the time when it flourished, not subsiding until the period between the two wars.

The main positive elements of this birth culture can be summarized as follows: constant companionship by familiar women, who had also borne children; direct or indirect assistance from the woman's husband; gifts of food, clothing and housework from the community; a postpartum rest period for the mother; a community fund of birth knowledge, including a small number of remedies in times of trouble; and the consideration of such help as part of a network of "turnabout" help rather than a service requiring payment.

The Disappearance of the Original Neighbour Network

The dying out of this birth culture in Ontario cannot be adequately explained by its having yielded to a safer system. As we have seen, there were indications in some parts of the country, never followed up, that undoctored birth was safer than the ideal medical birth of that time.

There must have been many reasons for the progressive disappearance of the popular birth culture, including increasing industrialization, which evidently led to a breakdown in the mutual aid network. Such a network seems to have thrived mainly in a farming environment.

Women's confidence in their ability to give birth and to help one another seems to have gradually diminished, beginning with middle class women. Thomas Hersey, author of the *Midwife's Practical Directory* (op.cit.), already lamented this fact in 1837.

> There is no subject... of which [these] women... are so entirely ignorant, as that of parturition, or delivery. Almost all of them are under the impression that labour is completed more by art than nature; hence the most noted accoucheurs are employed to attend during this interesting period: and professional men, in general, have no wish to undeceive on this subject, as their interest is too much concerned. I have often been astonished to see the credulity and ignorance manifested on these occasions. Thanks and blessings have been poured upon me, under the idea that I had saved their lives in labour, when I had done nothing but look on and admire the perfectly adequate powers of nature, and superintend the efforts of her work; and it is nature that accomplishes all, while the accoucheur gets the credit of it.[15]

Hersey urged mothers to instruct their daughters on the details of giving birth.

> If your daughters are too delicate and modest to receive the instruction of a mother on these subjects, they should be too delicate and modest to marry and cohabit sexually with their husbands.[16]

But modesty came to be seen as increasingly important even in the frontier areas, as settlement increased. There was a growing sense that decent people didn't have their babies in their small farm homes, where the children would know about it. Here, for example, is a letter written in 1927 by the reeve of a rural municipality in Saskatchewan, calling for the building of a hospital in his area so that local women could give birth there.

> My reason for this is that women in this country are treated little better than cattle in their own homes, in many cases the children being around when the mother is confined. If the children are to be an asset to the country they should not see such things under such circumstances.[17]

In addition to concerns about modesty, there came, after the First World War, a widespread taste for innovation, for being seen to be progressive and modern. This seems to have carried with it a disdain for many of the traditional, humble household arts. Popular magazines, which multiplied their circulation at this time and brought the views of the middle class into the most remote households, portrayed plain birth as inferior to modern, complicated birth. Techniques of modern birth already available at this time included induction, anaesthesia, and mechanical or surgical tools for separating the foetus from the mother. These new techniques were not available from neighbour women, who came to be portrayed as dangerously unequipped.

Midwives and the Law

As well as the general social changes that began to shift the outlook of women in the matter of handling birth, there were also more specific pressures. The most notable of these pressures was the strong and continuous effort by doctors from the 1850s onward to forge themselves into a unified profession and, incidentally, to include midwifery in their territory.

As Mary O'Brien wrote in 1828, doctors had not much chance to get birth business in the very early days of pioneer settlement. Settlement was so spread out that many doctors who arrived from Europe had a difficult time finding enough clients to make a living, and some of them took up other careers, such as government work or business. But as more settlers arrived from Europe and from the states to the south, doctors came to be more in demand, and their supply began to increase, particularly when local medical schools were established.[48] Doctoring came to be seen as a desirable profession, and medical schools multiplied, particularly in the United States. Some of them had a curriculum so short that they became known as "diploma mills." By 1870 there were 1179 regular (allopathic) medical men registered in Ontario, plus 93 eclectics (related to today's naturopaths) and 55 homeopaths. There may have been as many as 500 more who hadn't paid the yearly $2 to $5 fee to register.[49]

Technically, these men had a monopoly over the practice of medicine, midwifery included, from 1865 on. The first *Act to Regulate the Practice of Medicine* was passed in Upper Canada in 1795, making it illegal to practice physic, surgery, or midwifery without a licence. According to Robert Gourlay, the contemporary chronicler of those times, the Act was rather silly in the context of the scant population of most of Upper Canada.

> How absurd then to think of preventing the remotely scattered people from choosing whom they liked to draw their teeth, blood, and blister them! How absurd, how cruel, how meddling, that a poor woman in labour could not have assistance from a handy, sagacious neighbour, without this neighbour being liable to be informed upon, and fined.[50]

Although the act was in place for 10 years, the absence of any record of an Examining Board ever being convened suggests that it was never enforced.[51] In 1815 a new act was passed, this time exempting midwives. It provided

> that nothing in this Act contained shall extend or be construed to extend to prevent any female from practising midwifery in any part of this Province, or to require such female to take out such license as aforesaid...[52]

New acts followed in 1818 and 1827 with the midwifery exemption still intact. After this time a number of acts were proposed that did require licensing for midwives, but none of them passed until 1865. The 1865 act gave no exemptions from licensing. It made no mention at all of female midwifery.[53] A problem with this act was that what was illegal was not *practising* as a midwife but pretending to be registered under the act. Attempts to tighten the regulations met with resistance from the elected legislators. There was an angry editorial about this resistance in the *Dominion Medical Journal*:

> There seems to be an opinion prevalent, even among the members of the Provincial Legislature out here, that such an Act as the Medical Act is made for the exclusive benefit of the physicians, and while they are willing to help them out by giving them the exclusive control of medicine and surgery, by way of an offset for this favour, they leave midwifery open to public competition, as if it was something any ignoramus, mule [sic] or female could dabble in with impunity.[54]

There must have been a renewed attempt to include female midwifery in a new version of the Act in 1874 when it came up for revision. This resulted in strenuous objections from doctors, including this letter published in the *Canada Lancet*:

> Sir: In looking over the proposed amendments to the Ontario Medical Act, I find a provision to the effect that it shall be within the power of each Territorial Division to license midwives. This I wish to oppose most strenuously as being totally uncalled for in a country which is flooded with doctors who have been thoroughly trained, and are therefore much more competent to deal with these cases than a midwife. I contend that as we have spent some of the most valuable years of our lives in the study of what is said to be a "noble profession," as well as considerable money, that we should be protected most stringently against the meddlesome interference on the part of old women, and further this is to many of us country doctors a very remunerating part of our business, and we would not like to be made by Legislative measures to pay from $2 to $5 a year for the support of an Act which takes money out of our pockets, by placing it within the power of others who have never spent a farthing, nor lost an hour for the sake of becoming properly educated, to attend cases of confinement.
>
> Where I am located I have to contend with two of these old bodies and a quack, who I must say have been pretty successful in their attendance, as they get about 60 cases a year, which would amount in my hands to a very decent living for my small family.[55]

The objections to licensing midwives under any conditions prevailed, and female midwifery continued to be illegal. But this did not seem to stop women from helping their neighbours with births. It seems that in many places the change in the law made little impression on the people.

It was small wonder that doctors felt irritable about midwives. At a time when many families relied almost entirely upon their own resources in dealing with illness, birth offered a way for the doctor to gain access to the family, to make an income, and also to begin to build a relationship, to show his skills. He found himself in competition with women who relied on farming for their income and helped out at births on the side, and who therefore had no need to charge high fees, or even to charge at all. The doctors therefore had a serious leak in their system. The law was not working as a deterrent.

An oversupply of new medical graduates compounded their financial problems, and an increasing number of them began to move westward after the 1870s, to the newly settled farming areas in Manitoba. A similarly restrictive medical act was in place in Manitoba, but the young doctors found on their arrival in the West that the neighbour network was very strong and that it extended beyond birth to mutual aid in all kinds of illness. The reception given to the medical immigrants from the East, who came expecting to have the field to themselves, was not welcoming, on the whole. To add insult to injury, registration fees, which were mandatory, were much higher than in the East.

It was therefore in Manitoba, with the collision between immigrant doctors from the East and a highly developed neighbourly birth helper network, that the first serious attempts were made to use the law against midwives. The first stage of attack was in the form of letters from the College of Physicians and Surgeons to any midwife who had been reported by a doctor.

> Dear Madam:
>
> Information has reached this office that you are engaged in the practice of midwifery in Manitoba. As you are not licensed to so practice in this Province, it is my duty to ask that you desist. The law is very clear on this matter and the penalty severe.
>
> Yours truly
> The Registrar[56]

Some women must have been intimidated enough by such a letter to stop, but some replied defiantly.

> Your note received and contents noted. I have been nursing for 12 years in southern Manitoba. When what you call midwifery was forced on me, I did it. No one was as glad as I was when your boys with the bag came along, but somehow they have proved not very satisfactory. Did your informant tell you how many I had killed? Anyway that makes no difference. I have no licence. I think I charged once for that work, about seven or eight years ago. I got my face frozen. All I charge for is nursing. If you can punish me for that, do so at once, but let me tell you, I will go to prison and stay there until I die before I pay a fine and acknowledge that I have done wrong. I will go a little further and say that I will never do as I have done. I have always advised them to get a doctor: I will never do so again. They can do just as they like. When the child comes, I will do my best and save it. I have saved 70. The mothers are all alive. Two boys are dead, but lived until nearly four years of age. Can your boys with the bag say that? However, I am not going to multiply words. If you can punish me, now is your time. I am ready for trial any time, and if you have the power to imprison, I am ready.
>
> Yours respectfully,
> Mrs. K. Bell.[57]

Failure of the College to "protect the interests of registered practitioners from quacks and unlicensed midwives" led to increased rumblings of discontent, prompting a member of the Council of the College to urge in 1895 that they conduct some prosecutions to "demonstrate to the profession the need and usefulness of our existence.... We must look after and protect the profession, the College being the custodian of the interests of the profession."[58]

The College thereupon took a midwife called Mrs. Thiessen to court and got a conviction. As Mrs. Thiessen left the packed courtroom, the Member of Parliament for the area, Mr. Winkler, stepped forward and publicly handed her the money to pay the fine for her conviction. He later informed the College that he intended to bring forward a motion in Parliament to repeal the clauses forbidding medical practices without registration.

There was much debate among members of the College on what to do about this threat. Eventually they gave an assurance that if Mr. Winkler agreed to drop his motion they would stop any further prosecution of Mrs. Thiessen and she could carry on with her work. Legal counsel for the College wrote to the Registrar urging him to remind doctors that "no professional man is supposed to have any chartered rights. The Medical Act is for the benefit of the public and not for that merely of the profession."[59] Here lay an important difficulty with the Act. Although many doctors evidently believed that a restrictive medical act had protection of doctors' rights as its central function, the ostensible purpose of all the medical acts was the protection of the public. When a midwife was taken to court, and it became apparent that she was not damaging her clients, the midwifery section of the Act came to be seen as irrelevant, or downright mean. Prosecution of a midwife through the courts seemed only to gain public sympathy for her.[60]

During this particular trial, a defiant Mrs. Thiessen had threatened to challenge the legislation by pressing the College to give her a license. She appears to have been in a very strong position politically, and had she pressed her demand, Manitoba and perhaps even Ontario, by contagion, might have got licensed midwives. So why did she not pursue licensing?

The answer is most likely that Mrs. Thiessen, like the other women who helped out at births, had no desire to form a profession. Birth was an accepted element of folk knowledge, and mutual help was not separated out as an exclusive job assignment for anyone. What caused Mrs. Thiessen to challenge the College, and made her community rise up in her defence, was not that she couldn't get credentials to be an official midwife, but that the community was being interfered with at birth times. When the interference was stopped, the midwife disappeared back into her everyday life, and we hear no more about Mrs. Thiessen, nor about licensing for midwives.

In Ontario the courts do not seem to have worked well for the doctors either. In the two cases for which details are available, the midwives were let go. In the first case, in Toronto in 1899, a woman called Polly Whelan was convicted for practising medicine illegally by "attending and operating on Mrs. Rider and other women."[61] But on appeal the conviction was overturned on the grounds that it failed to "set out the particular act or acts by the defendant which constitute the practising":

> ...it was necessary for the prosecutor to delineate who the 'others' were. Secondly, there was a problem in the definition of practising. A precedent-setting case had defined practising as 'the necessity of proving more than a single act.' Since the other three cases occurred at different dates and were 'so remote from the particular act relating to Mrs. Rider, they constitute in law, if an offence at all, separate offences.' Thus, attending three different cases did not necessarily constitute practising.... [C]ontinuous attendance for two weeks, as in the Rider case, could have constituted practising; however, since Polly Whelan was not paid or promised anything by Mrs. Rider, then Polly Whelan could not be convicted.[62]

The second case was reported in the *Hamilton Times* in 1915. Here the midwife was found guilty of practising midwifery, but the magistrate declined to fine her, despite the requirement in the Act that he do so.

> If a woman can show she is competent, and has a certificate to show that she has passed her examination, even though it was in England, I do not think she should be punished. That is my opinion, so I will let the accused go.[63]

Doctors seem to have largely given up on using the courts, perhaps because of their unsuccessful efforts there, and to have concentrated on the slow but effective technique of gradually chipping away at folk customs with letters of intimidation.

> Letter from Dr. Adam Sibbitt to Dr. Gray, Registrar:
>
> Dear Sir: We have an old woman here by the name of 'Long' who practices midwifery. Lately, she has attended three or four of my patients, telling them she can do quite as well and not to pay the Doctor so much money. My object in writing you is to ask you to write her a sharp letter and give her a fright as these old hags by their tongue injure a medical man very much, in my case she has put me past some good fees. I would feel obliged if you would just give her a pretty strong letter.[64]

Dr. Benjamin Atlee from Halifax, when reminiscing about his career in obstetrics, told a story of a trained midwife working in Chester, N.S., who could not be convicted in court but was pressured by the local doctors to stop working.

> She had a place where she took the better class of unmarried women and they had a very nice place, and she delivered them. But the profession ganged up on her — every step she made was watched like a hawk.... They thought they were losing money — the midwives would take money away from them — and then, of course, there was the all-abiding anti-feminism — how can a woman deliver a baby, sort of thing.... They tried to hit her for malpractice but they couldn't do it. She gave up — she was the last one.[65]

The threatening letters were augmented by increasing numbers of articles in magazines and public statements by doctors on the dangers of non-medical birth.

The Victorian Order of Home Helpers

Paradoxically, efforts to convey the message that childbirth needed to be handled by someone with special training contributed to the creation in 1897 of a new movement that threatened the doctors' long-term interests more seriously than any aspect of the existing birth culture. This was the formation of the Victorian Order of Home Helpers by the National Council of Women, led by Ishbel, Lady Aberdeen, the politically adept wife of the Governor General of that time.

Lady Aberdeen had travelled across Canada in 1893, before she and her husband took up their post in Ottawa. She had spoken personally to settler women on prairie farms and she had also taken care to meet with the leaders of society in every large town, convincing them of the desirability of forming all women's organizations into one large federation to increase the influence of women in improving the country. In 1895, the National Council of Women was formed in Ottawa, with Lady Aberdeen as its first president. The organization cast about for a cause to be its first success — its significance to be heightened in the year of the Diamond Jubilee of Queen Victoria's reign.

Several eastern women who had moved to British Columbia suggested that there was a crying need for trained childbirth help for the pioneer mother in outlying districts of the country, particularly in the sparsely settled districts of northern

Ontario and the West. The National Council of Women in Ottawa, taking up this suggestion, specifically recommended that trained nurses not be employed. "The need was... for a practical woman who has some training and [who] will go from house to house doing all sorts of mercy and kindnesses, rather than the nurse just selected to go to a certain place to attend a certain case."[66]

As we have seen, doing favours "turnabout" was an important part of farming life in Canada. The members of the NCW now wished to institutionalize this part of woman's culture and to improve upon it by giving these women six months to a year's training, primarily in midwifery but also in first aid, simple nursing, and "household economy and sanitation." Rather than sending in strangers, they wanted to use the women of the communities as the basic building blocks of their new system: "Women who have already lived in these country districts and who are respected, and have the confidence of their neighbours, would be preferable to any others."[67] They sought to promote the use of experienced local women by restricting entry into the new order to women over the age of 28. (In the Order's difficult beginning period, when it was attacked from several different sides, misogynist sentiment latched onto this age restriction and expanded on it. The *Toronto Globe* published two lines on its front page on April 2, 1897: "The Toronto Globe treats its readers to an advance portrait of one of Lady Aberdeen's nurses. The poor thing is apparently ugly enough to stop a clock." The *Ottawa Citizen* explained to its readers that the qualifications of Lady Aberdeen's nurses were that they must be over 45 and well versed in the Bible.[68])

Sniping by the newspapers was only a symptom of the powerful opposition that ranged itself against the attempt by the National Council of Women to upgrade existing neighbour midwives into salaried, official health workers. The opposition began with the trained nurses, who had only just begun to carve out a new career suitable for middle class women. Through their successful transformation of what were previously pest houses into clean, respectable hospitals, these nurses had begun to gain public recognition. The cost had been the free labour of an apparently unlimited supply of student nurses, who were not hired back by the hospitals when they graduated, but had to create a private market for themselves. It was crucially important for trained nurses, through their nursing associations, to gain public recognition as the only legitimate adjuncts to medical men, so that the public would hire them in sufficient numbers to ensure their survival. Most nurses lived in genteel poverty — about half of the trained nurses were unemployed half of the time. The announcement of the formation of a new order that would employ a worker with a different and shorter training than the nurses' training was therefore regarded with dismay. The superintendents of the nursing schools of the major Toronto and Montreal hospitals had influence and went about in society, and they were able to acquaint the leaders of the National Council of Women with their feelings, politely but very firmly. They recommended that only trained nurses be accepted into the order and that the name be changed, since "Home Helpers" was too imprecise and did not denote a definite standard of attainment. Such nurses, said the superintendents, must be real ladies, in order to "serve in the highest of all service,"[69] that of "God's poor."

Lady Aberdeen reacted very skeptically, saying that "often a fully-trained hospital nurse is so accustomed to work with conveniences at hand and a doctor to appeal to that she would not feel able to deal with the work we should require of her in the scattered districts where she would be of most benefit."[70] She also pointed out that it was not God's poor that the Order was supposed to serve but pioneer settlers in isolated areas of Northern Ontario and the West.

But Lady Aberdeen did not prevail. The superintendents of the Toronto schools of nursing met and issued an official statement calling the Home Helpers scheme "thoroughly unworkable." Behind-the-scenes lobbying with influential friends of organized nursing, notably Lord Strathcona in Montreal, accumulated so much pressure on the National Council of Women that they yielded and redefined the new order. It would exclusively use trained nurses. There was no more talk of employing mature women already respected by their communities, and the name was changed to the Victorian Order of Nurses (VON).

Round One was over but Round Two was just beginning. The Victorian Order had not abandoned its intention of including midwifery in the work. As public meetings began to be held to raise funds for the project, doctors increasingly voiced their opposition. The trained nurses, although formally giving the VON their support, stayed completely at the sidelines of the ensuing debate. The issues became increasingly clear. Here was a proposal for nurses who would be working on their own. Who would be in control of what they did? The nurses or the doctors? Public meetings were very acrimonious. In Toronto a Dr. O'Reilly charged that the VON would "ruin the young doctors and the country doctors, as the people would send for the nurses instead of them."[71] Fund raising went poorly.

Lady Aberdeen paid a visit to her friend Sir Wilfrid Laurier, who was enthusiastic about the scheme and promised to help her out. He arranged to have the Victorian Order of Nurses proposed to the House as a National Memorial and to give it government funding. This information galvanized the medical associations of Ontario and Quebec, and on June 3, 1897, the front pages of the major newspapers of Toronto, Ottawa, and Montreal printed a resolution of total condemnation of the project by the Ontario Medical Association, set in bold black letters.[72] Laurier told Lady Aberdeen that a National Memorial for such a controversial project was now out of the question.

Remarkably, Lady Aberdeen and her supporters persisted. They continued to speak about the project at public meetings and to write letters; some of the supporters even went from house to house to convince people. A tour through the Maritimes brought some public enthusiasm but continued condemnation by the doctors. While on a trip to Boston, Lord and Lady Aberdeen received a letter from her support committee, advising her that "the articles on the Order and on those promoting it had become so virulent that they felt the Governor General and his wife should not be exposed to such an opposition, and they advised us to suspend operations for the present.... "[73]

Lady Aberdeen might have taken that advice except for an encounter with Dr. Alfred Worcester, a Boston physician who taught at Harvard Medical School, and also ran the only non-hospital training school for nurses in North America, in Waltham, Massachusetts. The superintendent of the school was Charlotte Macleod, a Canadian woman who had spent five months being trained for her job by Florence Nightingale herself. Miss Macleod and Lady Aberdeen apparently felt an immediate affinity for one another, and Dr. Worcester agreed to come up to Canada with Macleod to try to convince the doctors of the value of district nursing.

When he arrived, Worcester criticized the VON committee strongly for its vague stand on medical prerogatives. He had Lady Aberdeen issue invitations, handwritten by her, to 60 doctors in Ottawa and to a greater number in Toronto. He asked her to ensure there was plenty of good food, alcohol, and cigars at the meetings. The doctors came, and although the meeting began badly, many doctors standing at the food table with their backs to the speaker, Dr. Worcester's message eventually was heard. It was this:

> What advantage has a trained nurse over an untrained nurse? The untrained nurse is the ignorant, old-fashioned nurse. She thinks she knows everything, and the doctor next to nothing. These Victorian Nurses are trained to know their own proper sphere. They know too much to interfere with the physician. If they do not know this much, then it will be the physicians' own fault if they do not report any interference to the local management, when the nurse will be very quickly discharged by the rules of the Order. Any nurse found interfering with a practising physician, in any way whatsoever, will not be permitted to remain in the service of the Victorian Order of Nurses."[74]

At the end of both meetings, a small group of the most influential doctors waited upon Lady Aberdeen and told her that they would stop their resistance to the Order. The work as it was now proposed would focus on the urban poor, where there were enough doctors who could use the nurses to do visiting, change bandages, and so on. Money was to be raised to build cottage hospitals in outlying areas so that the nurses could work in the environment they were used to and so that doctors would be attracted to the area to supervise the nurses.

And so the VON began their work, having collected just $30,000 out of a projected $1,000,000. The medical journal *Canada Lancet* published a final editorial on the matter in January 1898. The journal emphasized that the medical profession had allowed the new order to begin work because "the former objectionable points, such as the proposal to train and examine their own nurses and to establish maternity hospitals where... the nurse was to reign supreme and the doctor appear only on suffrance, have at any rate been relegated to the background for the present."

In fact the charter of the VON expressly forbade the nurses from doing all except emergency midwifery; it also specified, as Dr. Worcester had promised, that if a doctor made any complaint whatever against a nurse, she would be immediately dismissed without any possibility of appeal. It was with these injunctions that the nurses began their work among the urban poor at the turn of the century.

One reason why the organization managed to raise so little money despite its energetic crusade was that it seems to have had difficulty catching the interest of the general population. The fierce debate mainly involved the developing professional groups (the doctors and the trained nurses) and the organizers of the VON. Politicians and clergy became involved because of their class connections with the opposing camps, but the debate seems barely to have touched those for whose benefit the organization was to be created. It may be that many ordinary people had not yet come to see themselves as needing professional help for illness and birth.[75]

The Country Doctor and the Midwife

It appears that the birth culture carried on very much as it had prior to the National Council of Women's initiative, gradually accommodating the rising number of doctors who declared their intention of taking a role in birth. The country doctor became a member of many small communities, not infrequently starting his career by working with traditional birth helpers. Obstetrical training up until the First World War, and even after, consisted of observing an average of four deliveries, often at a distance.[76] The memoirs of some country doctors describe their early experiences, nominally in charge of the delivery but actually following the lead of the far more experienced local women. Sometimes the relationship between the doctor and the traditional birth helpers seems to have been friendly and cooperative. Here is a story by Dr. W.A. Bigelow, relating his first encounter with midwives. He had just arrived in Hartney, Manitoba, in 1905, to establish a practice, when he was called out to a woman who was in convulsions because of eclampsia. It was the second case of labour he'd seen since graduation.

> There were two midwives present. They were wonderful women. We called them 'gamps,' but it would take a lot of nurses these days to do what those women could do in their practical way. These two had just what I wanted, a big wash boiler of water on the stove, as if they were going to scald pig.

Dr. Bigelow bled the woman, who was unconscious, and then delivered the baby. After the birth, he and the two midwives rolled the unconscious woman in hot, wet blankets, with the oilcloth from the kitchen table wrapped around the blankets to keep the moisture in. These hot packs were replaced every hour. The doctor also gave the woman several injections and a laxative. By 7:30 a.m. she became conscious. He had succeeded.

> I felt like a million dollars and I have never forgotten this case. It started me right on my feet in Hartney. After that, during the two years I was there, I had most of the maternity work to do.... The 'gamps' were great boosters of mine for the next two years of my practice there.[77]

Local birth helpers were perhaps not unwilling to cut back on the arduous responsibilities of travelling through bad weather at all hours to wait with a labouring woman, and many doctors for their part seem to have adapted themselves to the indigenous birth culture. When Dr. Helen MacMurchy of the federal Department of Health, Division of Child Welfare, made her first survey of maternal mortality in 1927, she pointed out that there were a number of country doctors with a very low maternal mortality rate who said they almost never used forceps or many of the other drugs and disinfecting agents that had come into vogue in mainstream obstetrics.[78] Some of them didn't even sterilize their equipment — the little that they used — defiantly maintaining that simple cleanliness and a minimum of intervention, even if it meant waiting a few hours longer, were better than more modern techniques. These doctors, although they may have been regarded as dinosaurs by their city colleagues, sometimes came to be held in high regard in their own communities, and so medical participation in the birth culture began rather naturally there.

The Advent of Modern Obstetrics: The Nurse as Propagandist

In cities and larger towns, medicalized childbirth multiplied its techniques after the turn of the century. Pituitrin, a drug for inducing and altering labour, began to be used around 1910. Chloroform, first manufactured in Canada by a Pictou, N.S., druggist for his wife in 1847,[79] came into almost universal use in the second stage of labour, increasingly followed by forceps delivery. The convenience for doctors in reduced waiting when births took place in hospital, as well as the additional safety for the drugged mother, made hospital birth seem highly desirable. There was a gap, however, between the medical birth culture and the traditional women's birth culture, and a great deal of effort was expended over the first four decades of this century in changing women's expectations around birth and bringing them into alignment with the new medical birth.

Trained nurses played a crucial role in this major campaign of public re-education. The metamorphosis of a large group of nurses from caregivers for the sick to propagandists for doctor-managed births had its roots in the precariousness of the nurses' position in the emerging medical system. After a student nurse had graduated from her hospital school, she often had great difficulty in finding a job. Home employment was problematic because it was sporadic, because the fees were too high for most families, and because the families that could afford a live-in nurse often treated her like a servant rather than a medical professional. Hospitals had neither the money nor the desire to replace their unlimited pool of free student labour with paid nurses. Until the 1930s, even large hospitals had only a handful of graduate nurses on their staff to supervise the students. Unemployment was thus a very serious problem for nurses. The solution seemed to be along the lines of creating an organization of government public health nurses, who would be paid through taxes and could aid anyone who was ill or in need of medical advice. Throughout the first two decades of the century, there was steadily mounting pressure by all sorts of women's groups to set up nursing services, be they municipally, provincially, or federally funded. The final incarnation of the VON was to be a model to show the efficiency of having a trained nurse enter into people's homes and to show them how to care for their sick and to demonstrate modern medical techniques.

Such public health nursing services, if set up everywhere, would go a long way toward solving the economic dilemma of the new nursing profession. The problem with this solution was that many doctors were hostile and suspicious of public health nurses, feeling that the nurses would be working independently and usurping medical prerogatives. This was particularly a problem because ordinary people, unaware of the politics of the situation, did in fact often regard the nurse as a cheaper and more suitable medical helper than the doctor, especially at times of childbirth. Increasing industrial development in the cities after the turn of the century brought in more farm families, and also more European immigrants, many of whom were accustomed to having home births attended by familiar women. The Ottawa VON reported in 1908 that their nurses were "experiencing some difficulty with maternity cases among the English immigrant women, who though with limited house room, object to going to hospitals."[80] In Hamilton around the same time, the VON nurses consulted their superiors as to whether they were permitted to accept referrals directly from clergymen.[81] The answer was, yes, in cases of chronic or terminal illness; no, in cases of maternity. But the nurses found an increasing number of requests to attend births without a doctor, not only on the grounds of economy, but also on the grounds of modesty. Year after year, the VON reports contained complaints from the nurses saying that they could not persuade the local women to go to a doctor when they were pregnant because they refused to expose themselves to strange men, preferring to wait and call a VON on an emergency basis when they were in labour.

The modern nurse had been taught the importance of early medical management of pregnancy, and was under strain knowing that there were pregnant women in her district and yet unable to have contact with them (until they were actually in labour and labelled an emergency). Alternatively, to commit an illegal act by independently giving prenatal care and arranging to attend the birth was an even greater strain, involving the certainty that, if reported, any such nurse would lose her livelihood.

One way out of this dilemma would have been another attempt to legitimize midwifery. In 1908 the Board of Governors of the VON again considered the feasibility of allowing "midwives as a recognized group qualified for independent practice." But after checking through the organization's Charter, the legal counsel for the VON had to report that the Charter explicity disallowed any move in that direction.[82] The VON would have had to go to Parliament to change the Charter. Medical opposition, already so strong toward public health nurses, would obviously not have diminished toward midwives since 1897, and so the matter was dropped.

The public health nurse then seems to have taken up the only solution remaining to her: to reduce the amount of direct care she gave and to redefine her position as someone who primarily did health education. This education went in two directions. The first was aimed at the doctor, so that he would come to see the public health nurse as someone who adhered strictly to medical orthodoxy, who promoted the importance of the doctor, and identified herself so closely with his views that she would never undermine him. The second part of the nurse's work was directed at the public, in a tireless round of unsolicited home visits, school visits, church group lectures, pamphlets, and magazine articles, emphasizing the importance of having one's health, and one's pregnancy, managed by a doctor — with the assistance of a nurse.

By the end of the First World War, the project by the nurses to gain medical and public recognition for themselves dovetailed with a movement among women's organizations to find a way around what they saw as male inertia and indifference to women's concerns. Years of deputations to politicians about contaminated milk, substandard housing, sweatshop labour, and insufficient medical and household aid for the Canadian mother had resulted in very little change. It appeared to the volunteer groups that the changes would not come about unless there was a powerful government agency to implement modern concepts of health and hygiene everywhere. The terrible loss of young lives in the First World War, followed immediately by two catastrophic influenza epidemics, put the matter of population replacement at the forefront of health issues. Concern about maternal and infant welfare mounted. The institution of Departments of Public Health followed immediately upon the first elections in which women voted,[83] and voluntary women's groups began to put much of their energies into ensuring that these Public Health departments became effective. The model most often proposed was that of an army, whose soldiers were the nurses and whose captains were the doctors.

It is easy to understand that, after the horror and heartbreak of the First World War, there was a public need to make a dramatic turn away from the past, and among other things, to invent a formula that would eliminate death or infirmity related to childbirth. Statistics about the safety of any particular birth techniques or locations did not even begin to be collected on any scale until after 1921, so the campaign, which grew into a crusade for modern childbirth, was conducted largely on the basis of the passionate beliefs of its proponents.[84] For the women's organizations, the expansion of public health nursing services was a very appropriate project. It represented a sweeping out of the old with a daring new vision of what was possible. Miss Mary Ard MacKenzie, President of the Canadian Nurses' Association, in a speech to the National Council of Women in Toronto in 1918, exhorted them to be visionary in their approach to maternity care:

> Canada occupies in this, as in so many things, a unique situation. She may profit by the experiences and the mistakes of all other countries. She has time to evolve a perfect system, would she set her mind to it, be guided by vision, and looking far ahead, see, with the seeing eye, the outcome. Will she rise to it? This is the burning question today. Our great menace in this connection is that Canada may slothfully adopt a midwife scheme that has proved a failure elsewhere, merely because she is too lazy, too indifferent, too unprogressive, too lacking in ideals to do anything else."[85]

MacKenzie painted a picture of a completely overhauled maternity care system involving improved education facilities for nurses and doctors, large-scale maternity hospital building projects, conveniently located prenatal clinics, and special grants and "re-education" to get nurses and doctors to fan out over the countryside instead of continuing to congregate in the urban centres. Her eloquence so captivated the National Council of Women that they disbanded their own nursing committee the same year, giving over all medical and health questions to the Canadian Nurses' Association, which then was able to use that very effective forum to further explain and promote its position to the leaders of society.[86]

The approval and active promotion of public health nursing by middle class women was an important element in the increasing acceptance of nurses' views on maternity care. It led, among other things, to numerous articles in the popular women's magazines whose circulation blanketed the country. An article in *Chatelaine Magazine*, July 1928, called "Must 1532 Mothers Die?" concluded:

> The dangers of the midwife, the fatality of exhaustion, the necessity of medical care and the realization of its availability from the beginning of pregnancy to term, should be so constantly preached that they become as much an accepted health measure as vaccination.[87]

And this is precisely what happened. Public Health nurses took their message everywhere, tramping from house to house, talking with women who were pregnant, not to offer any direct care but to persuade them to visit their doctors or the city's prenatal clinics. The work initially went slowly. By 1926, only 11.3% of pregnant women in Toronto had attended prenatal clinics.[88] Of 4002 antenatal public health visits to homes, 93% had been unsolicited — that is, the nurse had had to knock at the door and present her case to the pregnant woman. She carried with her little pamphlets of advice, such as this one published by Toronto's Department of Public Health in 1922:

> As soon as you believe you are pregnant you should place yourself under the care of a physician. Do not engage a midwife, it is illegal. If you cannot afford a private physician consult the public health nurse in your district who will advise you where such attention will be received free.[89]

Although the work went slowly among ordinary women, support from voluntary and government agencies multiplied. 1927 brought the publication of the *Little Blue Book* series of *Advice to Mothers*, written by Dr. Helen MacMurchy, an untiring campaigner for improved maternity care. This was the precursor of the *Canadian Mothers' Book*, and it was to have a run of more than one million copies before it was replaced by the next edition in 1940. The book emphasized the dangers of non-medical birth and warned against listening to neighbours for their advice or experiences. In reassuring and simple prose it advertised the advantages of having the attendance of a doctor and a nurse.

> *The Baby Comes:*
>
> Do not be afraid. Send for the nurse when you need her and your husband or the nurse will get the doctor in good time. The doctor will relieve you of pain as much as possible and will stay with you till you are quite safe. If this is not your first baby, it may not take more than one or two hours. Everybody will take care of you. The doctor and nurse will take charge of everything for you, till you and the baby are quite safe. And then you will have a good rest until you get your strength back.[90]

The optimism of these publications about the availability of medical care for pregnant women was perhaps appropriate in certain urban areas but in the remote areas of Ontario there was a wide gap between the assurances and reality. Here is a letter from a woman living near Englehart, in northern Ontario, addressed simply to "The Department of Health, Ottawa, Ontario."

> I was in a family way and took sick on the 26th of January, although I had not expected till February 15th. My husband was to be paid for some work he had done: on February 5th, but as it happened, I took sick sooner than expected and not a cent in the house. My husband went 2 miles on snow shoes to the nearest phone and called the doctors. They wanted to know if we had $25 to give them. My husband told them, no, that he had not been paid and explained how it happened. They said, "well, if you have the money, I'll go." My poor husband came back and a kind neighbour, as poor as we, but who by a miracle had five dollars on hand told my husband if the doctor would come for that, he'd lend it to us. My husband hurried back that distance and over the phone offered $5, but they refused to come... so for two days and all one long night I laboured and suffered with only the help of a poor little woman and my husband until at last I gave birth to twin boys... One of the babies was nearly dead when born. For an hour my husband rubbed and the woman worked with the little infant before it acted alive at all like the second one. Anyone who saw the way I suffered at the time proclaimed it a crying shame. It's a perfect disgrace to Canada that the mothers of the land must suffer without only a part even of the care necessary at the time.[91]

One of the unfortunate effects of the public health crusade was the undermining of women's confidence about birth.[92] Mrs. Renaud, the writer of the letter, actually accomplished a difficult birth rather well with traditional assistants — her husband and her neighbour. Although they all felt the lack of a doctor, they successfully revived the ailing twin. But there is no sense that this little group had any joy or feeling of accomplishment after the twins were born. They had accepted the idea that such a birth was unnatural, and Mrs. Renaud was left with a sense of something very wrong. Part of this sense may have come from the fact, to which she alludes only peripherally, that she and her husband and her four children were starving when she wrote the letter, and that she was again pregnant with her fifth child — at the age of 23.

> Please tell me what I can do when my time is come this winter. Is there no doctors for the poor who will be paid by the Government for saving the mothers... I have a little girl of 4 years past, born before we came here, then the two boys, and my last baby of last summer. There is no-one on this earth can care for these little ones like

> their own mother, and it would be terrible to have them handed into the care of others through neglect of me, the mother at a most serious time. If I were strong I would try and face the next one as brave as we Canadian mothers are, but I fear I have not the strength nor the proper nourishment before time to enable me to stand it, without some aid....”[93]

Mrs. Renaud emphasizes in her letter that she is seeking not material aid (“This is not a letter begging relief as you must be getting by the hundreds for the needy”) but medical aid, although she acknowledges, “If I had better nourishment I would likely have more strength for my battles and not require medical aid.” She seems to have felt, though, that by asking for food and clothing she would make people regard her as a beggar, whereas by asking for medical aid she would be understood as just asking for what was due to the Canadian mother. Mrs. Renaud had learned that if she expressed her problems in terms of health care requirements, she could get the government’s attention.

Although she had the government’s attention, it is unlikely that Mrs. Renaud was given actual medical aid. What she probably did get was a special volume of the *Little Blue Books*. For those women not near enough to hospitals or affordable doctors to have a modern birth, the *Little Blue Books* series had available another, smaller booklet, containing less text but more helpfully explicit suggestions for dealing with a normal birth. The existence of this booklet was not widely publicized, but if there were a “bona fide” enquiry, preferably with a letter of recommendation from a physician who could vouch for the family’s remote location, a booklet would be sent out.

The Movement for Legal Midwifery After World War I

In the opinion of some observers, the token availability of such information was not enough to help out women like Mrs. Renaud, and Miss MacKenzie’s vision of a network of perfectly equipped maternity hospitals right across the country seemed like castles in the air compared to the reality these observers saw around them. Two successive wives of Governors General from 1912 on made discreet enquiries, through leading members of the National Council of Women and through the Governors of the VON, as to whether they might be permitted to set up links with British organizations offering to send British midwives to remote areas in Canada. The obstacles always seemed too great, but in 1917 Dr. Thomas Gibson, an old friend of Lady Aberdeen’s and now chairman of the VON, proposed that the VON should launch an independent enquiry into three related questions:

1. The need for trained midwives in Canada;
2. The attitude of professionals and laymen towards their introduction;
3. The working of the system in England.”[94]

Dr. Gibson evidently had not anticipated the storm that his proposal would arouse. An influential NCW member and nursing supporter from Oshawa, a Mrs. Laidlaw, was the spokesperson for the opposition. She wrote him an angry letter pointing out that

> The women who take midwifery as a separate course and not in connection with any of the training schools of England, are of quite a different stamp unfortunately, and have not the social standing that women in the nursing profession deem necessary.”[95]

Mrs. Laidlaw demanded that all talk of a midwifery inquiry stop at once, threatening that if it did not, all the nurses would surely resign rather than be humiliated by being associated with such a backward organization. Although there were no signs of any resignations yet, Dr. Gibson backed down and cancelled the inquiry.

A more direct offer of midwives (euphemistically called “Mothers’ Nurses”) was sent by the British Overseas Nursing Association to the National Council of Women during the First World War.[96] The offer was initially greeted with some sympathy at the NCW meeting where the letter was read. A Mrs. Alfred Jones described conditions in northern Ontario and “the sufferings of women because of lack of Medical help and nursing.”[97] But the ladies at the meeting had difficulty in knowing what to do with the offer and directed a committee to consider it. The committee concluded that Canada was well on the way to solving its maternity care problems with its impending network of hospitals, and so the offer also came to no result.

The new superintendent of nurses of the VON after 1918 was a woman called Charlotte Hanington, who seems herself to have been not quite of the stamp that Mrs. Laidlaw deemed necessary. She was a widow who had spent some time roughing it on the Frontier, and she undertook a campaign, with the support of a very few remaining like-minded people in the women’s organizations, to build on the existing women’s birth culture. She was interested in upgrading the medical education of women already helping out at births and in keeping the home as the normal place of birth. In an article she wrote for *The Canadian Nurse* in 1918 she threw down the gauntlet to the supporters of the medical transformation of childbirth. The VON, she said, was an organization that believed the traditional ways of birth should not be thrown out wholesale.

> We have adhered doggedly to our original methods. We not only believe that it is the right of every child to be well born, but we go further and believe it is the right of every child to be born in his own house, in the bosom of his own family, as well as to be nursed at his own

> mother's breast — that the coming of a baby is a simple, natural process, and not an elaborate surgical operation."[98]

This and related statements put Mrs. Hanington very much at odds with the great majority of reformers, both volunteer and salaried, and earned her their cordial dislike. Rather than attempting anything as public as Dr. Gibson's midwifery inquiry, Mrs. Hanington quietly sent several nurses to New York to investigate the system of training and monitoring midwives that had been established at the Bellevue Midwifery School in 1911. They returned with documentation about the school, which had graduated 235 midwives by 1918. The midwifery course was free and lasted for 6 months, during which the students observed at least 100 births and handled 20 themselves. The maternal mortality of the births handled through the school was an astonishing 0.7/1000 compared to the rate of 6.5/1000 then current in Canada."[99] Records showed minimal septic infection and not one case of ruptured uterus. Mrs. Hanington's nurses brought back a long article written by Dr. J. C. Edgar, head of the training school, who was obviously pleased by the midwives' accomplishments but who was careful to point out that no matter how good the results looked, no one should be fooled into thinking that a midwife was as safe as an independent practitioner. "Who shall determine what is a strictly normal labour? The midwife? Never! She is incompetent to do so. Only the trained obstetrician can do so. The midwife can never stand upon her own responsibility."[100] Edgar went further than that.

> We wish to preface our remarks with the statement that we are opposed to the midwife; opposed to any plan or system by which she will be permanently retained and perpetuated as a practitioner of obstetrics. This was our attitude in the past; this is our position today.
>
> We have no desire to champion the cause of the midwife but merely to make the best of a deplorable situation — to render her less dangerous to obstetrics.[101]

The deplorable situation to which Dr. Edgar refers was the fact that midwives existed in New York in such numbers that they were attending 32.5 per cent of all births at the time of the VON's visit.[102] As to her danger to obstetrics, Edgar had evidently done well. No statistics were presented on the work of the non- Bellevue midwives — 1421 of them. But Edgar felt that it might have been the good influence of the Bellevue pupils that accounted for the fact that not one case of ruptured uterus or retained placenta (after the use of ergot), that could be traced to any midwife, had been admitted to the Bellevue and Manhatten maternity hospitals in over six years.[103]

The documentation brought back by Mrs. Hanington's investigators also included a report from Philadelphia, where no school had been set up but where midwives were simply being monitored by the municipal government. The government supplied the midwives with silver nitrate. Here also there was a very low rate of mortality and morbidity, so low that the supervising physician confided to a Montreal doctor in 1924 that he was afraid to publish the statistics.[104] And in Brooklyn, where the "midwife problem" had been handled by connecting midwives with social service agencies and encouraging them to bring their patients to the city's obstetrical prenatal clinics, the supervising physicians reported with surprise that the midwives were making good use of their service: "They bring clients very frequently, as often as every two weeks...(and) if we say that this or that patient needs watching up to the time of confinement, or that the case will be a difficult one, the midwife brings the patient back and encourages her to go into the hospital."[105]

Mrs. Hanington circulated this information as widely as she could among the nurses and the women's organizations but found that she could raise little interest. Finally, at the annual meeting of the National Council of Women in 1923, she made an impassioned speech on behalf of midwives.

> The medical profession of Canada is absolutely opposed to the midwife. The nursing profession is equally prejudiced against her. To practice midwifery unless by a physician is illegal; but with our characteristic waste of our natural resources approximately one half of our child life is under control before, during and after the birth of a class of workers who have been denied all opportunity for education for the very important work they are called upon to perform.[106]

Mrs. Hanington said that the medical profession was responsible for this state of affairs, and what was more, that the doctors' and nurses' obstetrical training was itself so inadequate that it was causing "increasing accidents at birth and (an) increasing maternal death rate...." She maintained that trained nurses were not even needed at childbirth.

> What our fifty percent of mothers must have is a woman, with sufficient training to attend a normal case at birth, who understands the care of babies, and above all who will assume the mother's household cares allowing her to rest, and this must be at a fee the household can afford.... At every nursing or medical conference there is the expressed desire for another worker, they have been trying to find a name for her, and occasionally you hear discussion regarding some form of education. We do not need to create her, she is here, and has been here for ages, the only satisfactory thing is to recognize her, license her, educate her and supervise her... it is a woman's problem and should be the first problem that the enfranchised women of Canada should consider and solve. Don't be deluded by legislation, or by political questions such as maternity benefits. Let us secure training for the women already doing the work, and have sympathetic inspection, so that the woman far away

> from the beaten path can, with confidence and safety, approach her hour of travail without fear.[107]

Although Mrs. Hanington did not go so far as to suggest the reintroduction of urban midwifery along the New York model, her assertion that political and legislative work to create a new health system were delusions could not have endeared her to her listeners. The speech was met with little discussion. Mrs. Hanington was trying to move against the spirit of the times, and so, of course, she was unsuccessful.

After this speech there was little official reference to midwives in Canada for another decade. The VON, somewhat discredited by the unprogressive attitudes of their leader, were replaced in the affections of the women's groups by the Red Cross, which had entered the field of public health nursing after the end of the First World War. *Chatelaine Magazine* ran a full page advertisement in 1922, picturing a Red Cross Nurse in battle uniform pulling up a tired-looking woman by the arms as though she were raising a soldier in the battlefield. This was the organization's model — they would use the techniques that had worked in the war to solve the problems of Canada's rural population. An army of Red Cross nurses was ready to do duty. In 1922 the Red Cross opened its first outpost hospitals in northern Ontario, at Haileybury, Dryden, and Ignace.[108] There were doctors in all these locations already, so the question of who was the field commander had already been answered.

The Red Cross: Unofficial Midwifery

As nursing stations began to be built in more remote areas, however, political questions about medical prerogatives began to surface. Annual reports were very discreet about nurses delivering babies on their own, and in Ontario the nurses seem to have managed to walk the line between serving the women of their district and not antagonizing the doctors. Between 1922 and 1933, 3600 births occurred at the 12 outpost hospitals, 11 nursing stations, and one hospital railway car. In addition, assistance was given at 500 births in homes, "many without doctors," the 1933 Annual Report revealed.[109] But the Red Cross nurses' maternity work was never officially called midwifery, and the organization was not challenged on it. In Manitoba, matters went differently. In an address to the Red Cross nurses in 1922, the Provincial Health Officer informed them that they had no right to conduct cases of confinement under any circumstances except emergencies. The statement was made at a time when four nursing stations in northern Manitoba were already being used as maternity centres, that is, over 80% of nurses' time was spent on maternity care, pre- and post-natal, and delivery. The head of the Red Cross in Manitoba wrote a letter to the Registrar of the College of Physicians and Surgeons the following month pleading with him to make some change in the ruling so that the stations could continue to operate.

> Specifically, the result of these instructions has been that — at Grahamdale in particular — the nurse has declined to commit herself in any way in connection with providing accommodation for confinement. The local committee at Grahamdale are exceedingly exercised and have addressed to Red Cross a very strong appeal that some solution of the difficulty be arrived at, and arrived at quickly. They point out that the people of the district subscribed in good faith and at, in some cases, heavy sacrifice, funds for the construction of a building; that as perhaps 90% of the cases are maternity cases, if these cannot be admitted and given attention, the station may as well be closed. They graphically illustrate the deplorable conditions that would result, and pray that in view of the understanding at the time the station was established, that they be not now abandoned.[110]

The Red Cross file does not relate what happened next. The correspondence does illustrate a pattern in the progress from the indigenous birth culture to the medical birth culture. Medical workers who succeeded in persuading people to replace local skills with the services of the city-trained nurse or doctor could pull out later and leave the community with no one. This might be because of political problems such as the one at Grahamdale or, just as frequently, because the medical workers who had been parachuted in from the cities experienced the frontier areas as lonely and barren places. The nurses increasingly reported that the midwifery work they were doing in homes was impractical, not because they encountered so many crisis situations in which it would clearly have been safer to have the facilities of the hospital, but rather because they came to see home births in these surroundings as terribly inconvenient. Their complaints dealt with substandard housing, absence of running water, absence of medical equipment, and the absence of the familiar medical routines of the hospital.[111]

The aim of the Red Cross "army" of nurses was not to fit themselves into the routines of the families they visited but rather to raise the log cabin or mud shack births closer to the level of medical birth. A British women's organization sent over crushable chloroform capsules so the Red Cross nurses could give pioneer women a taste of modern obstetrics. This work won warm praise in articles in the women's magazines, such as this one in the *Canadian Home Journal*.

> Can we who live close to our doctors and within a few minutes' motor ride of hospitals thoroughly equipped to take care of us in every way, really vision what it means to these women miles and miles from other human habitation when the door opens and a Red Cross nurse with her armamentarium comes in? Another woman to talk to, someone to assure her she is going to be 'all right'? to take command of the little home and make delivery safe, and since the crushable chloroform cap-

> sules are available to mercifully obliterate for her the worst of her labour. Soldiers, aren't they, these pioneer mothers?[112]

Although the image of the Red Cross nurse saving the day was a very romantic one, the reality, as we have seen, was often lonely and tiresome, as well as fraught with the political problems of doing unacknowledged midwifery, often with no training for it. The Red Cross and the VON combined, therefore, never recruited enough nurses or funds to serve more than a small fraction of the rural population.

As towns grew larger and the number of doctors increased there was a steady increase in the number of doctor-attended births and also an ever-increasing number of new hospitals. Even so, throughout the twenties, many births in remote areas were probably still handled by neighbours. Estimates of how many varied widely, and it was apparent that no one really knew. Charlotte Hanington suggested in 1923 that "50% of all maternity cases in our Dominion are delivered and cared for by midwives,"[113] but she may have been exaggerating for effect. By 1929, only 24.5 per cent of births in Canada took place in hospital, but this does not tell us how many were medically unattended, since many doctors still came to births in homes. In 1925, a public health nurse, Margaret Duffield, gave it as her opinion that:

> the inevitable 'handywoman'... appears to do the major part of the obstetrical nursing in [Ontario].... [W]e must remember that [medical aid] is more often than not crowded into urban districts, leaving the stray handy(?) woman in command of the rural field.
>
> If we are satisfied with this condition we of course need not hope to reduce our maternal mortality rate.[114]

Nurse Duffield assumed that care by amateurs must have caused Ontario's high maternal mortality. As we have seen previously, however, medically unserviced areas in northern Ontario at the time Duffield was writing actually had a considerably lower maternal mortality than the provincial average.

The Age of Obstetrical Experimentation

Some obstetricians in teaching centres felt it was more likely that new medical innovations caused the high maternal mortality. Despite the general enthusiasm for modern obstetrics, there were cautions in the Canadian medical literature about the dangers and excesses of the new methods. At the end of the 19th century, when puerperal fever (infection contracted during or after birth, popularly known as "childbed fever") began to be more common in city hospitals and homes, it became the fashion to treat fevers very aggressively by scraping out the uterus and douching with harsh antiseptics, in some cases even prophylactic douches, before delivery. In 1896 the *Canada Lancet* printed this angry editorial.

> If these so-called progressive obstetricians had taken the pains to consult the statistics of the country doctor or midwife, they would not have rushed to such a foolish extreme. They would have discovered that the old practitioners who had delivered women by the thousands, never possessed a syringe, curette, or anything of the kind, never used bichloride solutions, or any other antiseptic solutions for any purpose, and as, a result, never had a case of puerperal septicaemia.[115]

The editorial was repeated in a different form for another two decades before the conservative treatment of infection once again came into ascendency. Excessive use of the caesarean operation and the routine use of chloroform both received very critical coverage in the medical press, again with little result. Conservative clinicians stood at the sidelines shaking their heads as the majority of their colleagues adopted a variety of new and virtually untested anaesthetics,[116] encouraged by strong public approval to be daring in their innovations. Episiotomy and forceps became routine, and caesarean birth gradually came to be seen as a more efficient way to extract a baby, despite a mortality rate four times that of vaginal birth.[117] As obstetrics moved further and further away from the indigenous birth culture, the meaning of "conservative" also changed. Dr. J.W. Williams' first obstetrics textbook in 1903 had been scathing about what he considered the "fad" of routine episiotomy; in the 1920s he advocated routine episiotomy as a part of normal conservative obstetrics. He did not base his change of viewpoint on any studies of effectiveness that had been done, but on the wider concept of "clinical impression" as it was agreed upon by the majority of obstetricians.

But no matter how much the definition of normalcy was broadened, there were always obstetricians and general practitioners who were willing to go further. Routine inductions to prevent babies from growing too large, high forceps deliveries through a partly dilated cervix, routine turning to the breech[118] and pulling the baby out by the feet, all had their apologists. Leading obstetricians announced that the modern woman needed all their interventions because she was dangerously close to being unfit for childbearing. She was psychologically unable to go through the agonies of labour and physiologically too constricted to allow the baby safe passage. An editorial in the *Canada Lancet and Practitioner* in 1928 entitled "Labour — Physiological or Pathological?" had the following quotation from the latest edition of Dr. Joseph DeLee's obstetrics text:

> Can a function so perilous (he asks) in spite of the best care, which kills thousands of women every year, leaves at least half of the women confined more or less invalid, and a majority with permanent anatomic changes of structure, that is always attended by severe pains and tearing of tissue... be called normal?

With this image of woman dominating the obstetrician's mind, there came to be an epidemic of obstetrical interventions all over Europe and North America.

During this time, nurses continued in their role of converting the populace to the image of safety in the competent hands of doctors and nurses. This is not to say that there were not some critical comments from nurses, but they were generally very restricted in what they were allowed to say,[119] particularly in print. For the most part, public statements about maternity care by nurses continued to emphasize the need for medical birth and the danger of the midwife. Nurse Stella Pines, a regular columnist about baby care for *Chatelaine Magazine*, began her instructions to the Canadian woman each month by telling her that she must have the care of a doctor.

> The first and foremost necessity has already been pointed out in previous articles; that is, the early interview of doctor and nurse. It is just as important to have a well-trained nursing service as medical, for without the former the latter is inadequate. In most countries where the untrained midwife or friend has attended confinement, the mortality is higher, as also is puerperal septicaemia, commonly known as blood poisoning. In countries where midwifery is practised, it has taken years to reach the goal of having untrained women replaced by the trained and experienced nurse.[120]

Miss Pines' impression, recorded here as fact, was that midwives were the cause of maternal mortality and morbidity due to puerperal fever. In the absence of studies or even inventories of the results of various techniques and birth locations, her idea seemed logical and sensible.

In the same year that Miss Pines wrote this, however, a new element entered the obstetrical scene — the first methodical inventory of the effects of medicalized birth in the English-speaking world. Public health authorities in Aberdeen County, Scotland, had been involved since 1917 in meticulously collecting detailed information on every maternal death in their region. They stopped in 1927, having amassed records of 252 deaths in 37,984 confinements, both urban and rural, at home and in hospital, attended by various types of workers ranging from midwives to general practitioners to specialists in obstetrics. When the data had been analyzed, the findings were summarized in medical journals world wide.

One disturbing fact stood out, which was described in the *Canadian Medical Association Journal* of 1929:

> The death rate per 1000 maternity cases delivered by midwives was 2.8, by doctors 6.9 and in institutions 14.9. The last figure, which includes only cases untouched before admission, is surprisingly high....[121]

In Canada, unobserved by Nurse Pines but noted by some medical officers of health whose business it was to examine mortality data, hospital mortality was also very much higher than home birth mortality (see Figure 1).[122] Birth unattended by a physician, however, was not a separate category in Canada's vital statistics, and so its results were unknown. The difference between institutional and home birth mortality had always been explained by the fact that women who got into trouble during labour were transferred to hospital and that then the hospital had to count their deaths against itself. The Aberdeen inquiry had eliminated these cases and still the mortality stood very much higher in hospitals. Although some of this difference was undoubtedly caused by the tendency to admit women with difficult pregnancies to hospital for their births, the level of prenatal care in Aberdeen County was as low as it was in Ontario at the time (probably around 25%), and so medical screening would have been a slight factor. The Aberdeen study received a great deal of attention in the Canadian medical press and resulted in a brief reopening of the question of midwifery. Several leading obstetricians suggested that legal midwifery should be introduced in Canada. Physicians who were against it felt a need to defend their position.

> Some enlightened opinions, high up in the obstetrical world, hold that we ought to revert to the midwife as an easy means of remedy. This argument has to be met frankly and my answer applies only to Canada. Let other countries find their appropriate solution. We have committed ourselves for generations to the policy of physician accoucheurs. We cannot turn back now even if we should wish to.... That is the positive answer. The negative side is that we have practically no midwives, nor have we a class of women who would be willing, in large numbers, to undertake this type of work. It would take years of training to make them efficient. Lastly, our public, (except those recent imports from the near East) are not favourably disposed to midwives, and the public have the say as to who may or may not attend them in labour. What an indictment of our training in obstetrics to admit that a midwife, with poor schooling and short medical training, is a more effective obstetrical agent than is a graduate in medicine! No, the fault lies with our methods, and the earlier we recognize this and apply the remedy, the sooner will obstetrics enjoy the immunity which it so richly deserves.[123]

In an effort to alter their methods, hospitals in Ontario imposed more stringent controls on their maternity patients. Labouring women were strictly isolated from non-medical people, and medical personnel, particularly nurses, redoubled their efforts to de-germ the woman and her environment. "Medically unnecessary" approaches to the labouring woman were discouraged, and procedures as simple as an examination to check dilation were preceded by surgical antisepsis. The woman herself was strictly instructed to keep her hands away from the lower part of her body and to wear a mask if she had a cold, lest she transfer her mouth germs to her vagina and thus be the agent of her own demise. Medical anxiety about self-contamination was so great that delivery tables had straps attached to them to tie down the woman's wrists.

Despite such measures, mortality did not go down. In 1933, two more devastating reports appeared, this time originating in the United States. Based on an investigation of 2041 maternal deaths in New York City from 1930 to 1932, a New York Academy of Medicine study concluded that two-thirds of the deaths could have been prevented had the best medical knowledge been applied. It accused many doctors of lack of judgement, lack of skill, and carelessness. There were favourable comments about the work of midwives and about the advisability of home birth.[124] This study was followed by an even wider-ranging one that included 11 states, published by the White House Conference on Child Health and Protection later in 1933. It emphasized that despite the increase in hospital delivery, prenatal care, and aseptic technique, maternal mortality had not declined between 1915 and 1930. What was more, the number of infant deaths from birth injuries had increased by 40 to 50% from 1915 to 1929.[125] On the subject of modern woman's unfitness for birth, Dr. Iago Galdston, secretary of the New York Academy of Medicine, had this to say:

> There is nothing to show that our women cannot, at least in a biological sense, deliver their babies.There is some suggestion, however, that this generation has brought forth a different race of obstetricians. How otherwise account for the findings reported in [a study in] Philadelphia? In one hospital the operative incidence on the *private* floor service was 50%, while in the ward service of the same hospital it was only 4%. The results did not indicate that the ward patients were being neglected.[126]

It appears from Canadian medical journals that physicians in Canada, and particularly in Ontario and Quebec, took these American studies to be equally applicable here. When they looked at the countries that had the lowest maternal mortality rates — Holland, Denmark, Sweden, Norway, and Italy (all less than half of Canada's rate) — it was undeniable that they all had at least one thing in common: extensive use of midwives. Suggestions appeared in the *Canadian Medical Association Journal* that perhaps it was time to send someone to those countries to actually examine their system.

> We are aware that some countries have a lower maternal death rate than we have in Canada, but we do not know the reason for this. We may jump to the conclusion that it is because there are trained midwives in these countries, but we do not possess enough information to enable us to say that the trained midwives provide the explanation in whole or in part. It does seem that the time has arrived for a clinical study of conditions in these countries. If it were possible to secure an obstetrician of wide experiences who is free from established personal opinions as to the explanation of these low death rates, he could add considerably to our fund of knowledge by visiting these countries and studying the subject clinically, not statistically.[127]

Evidently such an obstetrician could not be found and no such study was carried out. However, several studies were done in Canada during this time on the subject of maternal mortality, particularly in Manitoba and Ontario.[128] Their findings did not duplicate the Scottish or the American studies, perhaps because there was a major difference in methodology. The Canadian studies gathered their information by sending out questionnaires to physicians, who filled them out, or not, as they chose, perhaps adding some information about medically unattended births, if they had heard of any, in their area. As the authors of a 1934 maternal mortality study in Ontario themselves pointed out, "careful study of the 257 questionnaires ... showed that it was impossible to assay the quality of medical care from such a source."[129] In the American and Scottish studies, on the other hand, investigators had reviewed all statistical material pertaining to each maternal death, including hospital records, and had also attempted to interview the attendant involved in each birth, as well as the family of the dead mother.

The American studies in particular were quite critical of medical practice, and tended to evaluate rather than justify current obstetrics. The Canadian studies tended to give a composite of what doctors were currently feeling about their practice, and presented their ideas about what might be causing the high maternal mortality. Most Canadian doctors seemed to feel that the responsibility lay outside themselves, either with dirty midwives, or with the stubborn refusal of potential clients to come for prenatal care. In their survey of Ontario mortality in (1933), Drs. H.E. Young and J.T. Phair felt that women were themselves to blame for the poor care they got during pregnancy, because of their

> rigid adherence to ultra conservative ideas, [a] peculiar diffidence which all women associate with the pregnant state; and their apparently inherent desire to conceal their condition as long as humanly possible, even from those most intimately associated with them.[130]

Public Health Nurses Between the Wars: Obstetrical Schizophrenia

As we have seen, women who were unwilling for reasons of money or modesty to present themselves at a doctor's office, were a trial to the public health nurses who were by then working in large numbers in urban areas. Elizabeth Smellie, who succeeded Charlotte Hanington as head of the VON, said in a speech at the Canadian Health Congress in Toronto in 1928 that of 90 cases picked at random in one VON district, 34 were emergency cases.[151] Presumably these were the women who preferred just to "chance it" rather than going through prenatal care with a doctor, and who, therefore, didn't call the VON until they were actually in labour. But if these women were actually still holding onto parts of the traditional birth culture — that is, birth with women attending and minimal exposure to strange men — they were by now very out of step with up-to-date childbirth. Elizabeth Smellie emphasized that "with many women there is the necessity of dispelling the illusion that having babies is a perfectly natural process, which if left alone will take care of itself."[152]

The public health nurses continued their patient work in this direction, dispelling any notion that birth was a normal event. The VON were in an odd position here. They seem to have continued to do a high number of these "emergency births" — in effect practising midwifery. In 1928, of 14,070 maternity cases attended by VONs all over Canada, 4,201 were emergency cases, meaning that many if not most were accomplished without a doctor. Although the VON counted against its own mortality rate any death occurring after one of their patients had been removed to hospital, their rate that year was 1.6/1000.[153] The country as a whole that year had a maternal mortality rate of 5.6/1000. In 1932 the VON were again able to report an overall mortality among their maternity patients of 2/1000 (1/1000 in Toronto) compared with the national mortality of 5.1/1000.[154]

This could have been taken as evidence that midwives, working either alone or with doctors in domiciliary practice, could be effective agents for lowering maternal mortality. Instead, a *Canadian Home Journal* article suggested that the VON's main accomplishment was their ability to prevent their clients from forcing the doctor to do something rash.

> ... the VON know that the doctors are very busy men and, while they encourage the patient and carry her along as gently and kindly as can be done, they do not call the doctor until he is needed. This means that, with the doctor not there to be importuned with pleas of mother or relatives to "do something" to speedily terminate the labour, there is less instrumental interference. Could this not be a factor worth considering in the low death rate among cases attended by the VON?[155]

This was rather faint praise for the VON, and certainly didn't lead the *Home Journal* to examine the potential benefits of midwives for Canada. In fact, the VON's superior statistics were constantly used to explain the need for *more* doctor involvement in births. In an article on obstetrical advances in the *Canadian Home Journal* in 1941, Dr. E. B. Pugsley used the VON figures to deliver a stinging rebuke to neighbour midwives.

> The VON reports that in 1939 they cared for 17,308 of Canada's new mothers and only 20 of them died for each 10,000 live babies born — less than half the number for all Canada. Why? Because the VON insists on each mother going to a doctor all through her pregnancy and after the baby's arrival, until all danger of complications is past. This gets results!... Granny scoffs: 'Such newfangled notions! Why, I had 16 babies and never a doctor for one of them.' Yes Granny, you did, and you were lucky: but remember that radiant young bride next door who died suddenly in convulsions a month before her baby was expected? *She* didn't have a doctor either, and no one told her that the puffy face and limbs meant danger; no one sounded the 'Alert' siren when the grim bombers of death appeared on her horizon. She could have been saved if you, the mother of 16, hadn't sneered at 'such fussing over a natural event.'[156]

What these writers omitted to say was that the comparatively very low death rate of the VON was all the more remarkable because the doctors involved in their cases were not specialists, that most of the deliveries occurred at home, that many of those attended were poor (a 1939 survey showed that only 16% of VON clients were financially 'comfortable')[157] and that between one quarter to one third of the births were done on an emergency basis, with little or no previous medical contact and perhaps no doctor at the delivery. Still their results were excellent in the context of the time, perhaps even better than was generally reported. At the annual meeting of the Canadian Medical Association in 1934, Dr. Fred Routley of the Ontario Red Cross commented during discussion that Red Cross nurses working in remote areas were doing remarkably well.

> In the past 10 years, we have conducted several thousands of confinement cases. We have absolutely refrained from publishing statistics because we do not want to appear to show results which would look too good to be true. Our nurses last year attended 110 cases of confinement without a doctor being present, and without one mortality.... We practically never see a case of puerperal septicaemia in the home.[158]

Why did these facts not compute? Perhaps medical reformers and medical writers in the press were so committed to the policy of increasingly medicalized birth that they were quite incapable of looking in another direction.

Did some women continue to help one another in their accustomed ways, despite the persistence of public health reformers and the lure of modern ways? There is evidence that a small number did stay with their traditional practice. An account written in 1937, by Dr. J. H. Duncan, entitled "Neonatal Mortality (A Study of an Eleven-Year Period of Obstetrics in a Small City)," mentions in passing:

> A not very flattering fact emerges when one notes that the average [neonatal mortality] rate for the 17 doctors [of Sault Ste. Marie] is 7%, while the average rate for the

> whole series is 6.5%, accounted for by the absence of a neonatal death among 564 unattended by professional assistance.[159]

Since there was obviously no shortage of doctors in that town, one could assume the absence of professional attendance was a choice. But it was clearly a choice being made less and less often. By 1935, half the births in Canada took place in hospital, and after this critical point was reached, it took only a little more than a decade to get most of the rest into hospital as well. There was no place for the traditional birth culture in hospitals.

Despite the growing popularity of the hospital as the place of birth, the preface of the *Canadian Mother and Child* estimated that 20,000 mothers across Canada delivered their babies without medical attendance in 1943, and 16,000 in 1947.[160] Presuming these to be women in medically unserviced areas who relied on neighbours from necessity rather than choice, the author of *The Canadian Mother and Child* made the decision to include a chapter on birth without a doctor in the 1940 edition so that the neighbour women might use the book as a resource. For this he was strongly criticized by Charlotte Whitton, head of the Child and Maternal Welfare Council in Ottawa:

> .. we must raise the question whether there might not be a danger, say in certain parts of New Brunswick, in northern Ontario, and other provinces, of this [chapter] being used by practical nurses and midwives to increase independence of the medical profession amongst certain ranks of the population, particularly among those of foreign birth.[161]

Dr. Couture defended himself by saying that he was only trying to provide aid in a very undesirable situation and that, in his experience, no mother would voluntarily have a baby without a doctor. Whether this was entirely true is a question, especially since the 1947 edition begins with a reminder to women that doctors are more important than is generally acknowledged:

> A common opinion is that it is unnecessary to see a doctor, and this is based on the fallacy that, in the past, results were equally satisfactory when a doctor had not been consulted for pregnancy or even for childbirth.

Dr. Couture sought to counteract this error by filling the book with injunctions to the mother to avoid discussing her pregnancy with friends or neighbours and to place her trust in her doctor. He also enlisted the help of Dr. Roy Dafoe to convince women of the necessity of medical birth. Dr. Dafoe was the doctor who delivered the Dionne quintuplets, and he became an instant expert on all aspects of birth and childrearing after the quints were born. Dafoe had a radio series in which he gave advice to mothers, and this series was so successful that in 1939 Dr. Couture arranged to have the talks transcribed for a booklet. It was to be called *A Country Doctor Speaks to Women*. The printing was cancelled because of wartime financial restrictions, but the original is still preserved. Dafoe reminded the pregnant woman of her need for medical care in a section called "Heaven's gift":

> During pregnancy: It is not necessary for me to remind you again that this is a time when you must place yourself unreservedly in the hands of your medical advisor, and when the best help you can give will be in the spirit of complete submission and cooperation. Remember that the various measures you will be asked to take are essential for your welfare and for the safety of your baby. The doctor knows by experience (and his own skill is backed up by all the accumulated wisdom of his profession) just what to do for you.[162]

One of the areas in which the experience of the doctor needed to be acknowledged was the decision as to place of birth. In *The Canadian Mother and Child*, Dr. Couture emphasized that the choice of birth at home versus birth in hospital must be made by the doctor.

> He is most assuredly interested in obtaining the best possible results in your case, and it is only fair that you should give him your full cooperation by allowing him to work under conditions of his choice.[163]

The conditions of the doctor's choice were most assuredly those found in hospital and so, by the 1950s, there were only fragments of the original birth culture left in Canada, mostly in areas where the population was too scattered for a doctor to be able to make a living.[164] Many of the women giving birth in hospital at that time participated in the event in a deep haze of anaesthesia, so that the approaches of strange men and women, so unusual in traditional birth culture, were not noticed, and the loneliness of their aseptic isolation was forgotten.

Beginning in 1937, maternal mortality, together with infant mortality, took a sharp fall, which here in Canada was attributed to the enormous increase in hospital birth, despite the simultaneous fall in European countries that continued to have domiciliary midwifery. This fall (which had its dramatic beginning in the year before the introduction of the first antibiotic, but which is widely accepted as being largely *caused* by the discovery of antibiotics) was something of a mystery to leading obstetricians of the time. In 1940 Dr. A. H. Sellers, the Chief Statistician of the Dominion Bureau of Statistics, reported that while maternal mortality was the lowest since collection of statistics had begun in 1920, "no special change occurred during 1937-38, either in policy or in practice, which would appear to account for (the improvement)."[165] But while statisticians and some obstetricians might have been mystified by this development, the majority of the medical workers were only too glad to announce that their labours had finally borne fruit, and that universal medicalized birth had brought obstetrics "the immunity which it so richly deserves." The dazzling success attributed to obstetrics[146] stilled, for a few years, regrets about what might have been lost.

"Cruelty in Maternity Wards"

In November 1957, the editors of the American magazine, *Ladies' Home Journal,* which had a wide circulation in both the U.S. and Canada, published a short letter in their mail column, anonymously signed "Registered Nurse," which asked the magazine to investigate "the tortures that go on in modern delivery rooms". Among other things, it mentioned strapping the mother to the delivery table, isolation of the mother, and slowing down the birth to wait for the doctor to come. There was such a flood of letters, from Canada as well as the U.S., that the magazine decided to turn them into a full-length article entitled "Cruelty in Maternity Wards." The letters dealt with the despair and anger of women about their birth experiences, and were interspersed with remarks by obstetricians, sometimes defensive, but often agreeing with the women.[147] The article again resulted in so much mail that a follow-up article appeared, with a second set of letters. This article, even stronger in tone than the first one, claimed that hospital birth culture was producing "tortures not very different from those used in Japanese prisoner-of-war camps." At the end of the article, the writer called for two major changes — that husbands be allowed into delivery rooms so that they could comfort and protect their wives, and that an immediate program of midwife training begin all over the United States.[148]

Although these and other changes were a long time in coming, the *Journal* article signalled the beginning of a popular movement that began to back away from the form birth was taking under medical control. This movement — or, more properly, sentiment — was to be found in Canada as well as the U.S.

One of the features of the *Journal* article was the correspondence received from nurses who were either appalled by the things they had witnessed or who had themselves been subjected to unhappy childbirth experiences. The nurses claimed, and the *Journal* editors agreed, that within the hospital nurses were powerless to stop cruel treatment, or even to speak about it, because of fear of dismissal. As more women began to question the medical birth culture, however, nurses slowly began to raise their own doubts in public. In 1959, two articles appeared in *The Canadian Nurse.* The first was written by a Canadian nurse, Norah Cunningham, who had just taken a public health course at Columbia University in New York. The course had a midwifery component, and when she returned to Canada, she found she had lost her taste for hospital obstetrics.

> Recently, in a hospital obstetrical department, I found myself puzzled, frustrated, and rather unhappy with practices that I was seeing and taking part in. Many times mothers were left alone in labour and appeared distraught and tense. In the delivery room with the extensive draping and positioning the mother so often seemed forgotten except as a uterus. There was little if any effort made to allow the mother to see and hold her baby. In a home delivery service the situation is so different that it is startling. The type of women seen in the hospital and in the home service are much the same but in the home atmosphere there was a feeling of nearness, helpfulness, a close working relationship.[149]

Nurse Cunningham was convinced that if a way could be found to let the nurse be less involved with "handing sutures, forceps, swabs...at the foot of the delivery table" and more involved with the mother, the satisfaction of nursing could be much increased.

Her article was followed immediately by another on the same subject, entitled "The Role of the Nurse-Midwife in Great Britain." The writer, a nurse from Saskatchewan, concluded by warning her readers that doctors did not make appropriate midwives, and that their focus on childbirth as pathology was pulling the nurses down with them, forcing them to have the same negative vision.[150]

When it came to making definite recommendations on how maternity care could be improved, both nurses ran into difficulty. The rigidity of the hospital hierarchy seemed to overpower their imagination.

Government Midwives in Canada's North

For those nurses who felt changes inside hospital maternity units were too slow in coming, a possibility already existed to do midwifery work, legally, in Canada. The scope of this work increased considerably in the 1960s, but had been going on at the margins of settlement since World War I. As we have seen, the pressure from volunteer groups to multiply health services resulted in little more than "health education" campaigns in many parts of the country. But this was not the case everywhere. In 1919, at a meeting of the United Farm Women (UFW) and the United Farm Men (UFM) of Alberta, a resolution was passed calling on the government to supply midwives to remote areas. The UFW and UFM were powerful enough that the Minister of Health of Alberta "stated on the public platform and on the floor of the House that the Government would pay the travelling expenses and tuition fees of all such nurses [in remote districts] provided an institution could be found that could give them such training."[151]

By the time the Minister said this, 10 or 12 nurses were already working as midwives. In the following two decades the work increased to 27 districts, using mainly British-trained nurse-midwives. In an article entitled "Alberta Shows the Way," Kate

S. Brightly, their superintendent, was careful never once to use the word "midwife" in connection with the nurses. But she was clearly very proud of the service:

> Little is said about it, but Alberta has the distinction of being the only province in the Dominion which has a definite policy which makes provision for supplying this particular kind of nursing service to rural communities... Much could be said of this home care for the mother and the influence it has on the entire family; the preparation that everyone can take part in; the looking forward to and planning for the event, and above all, the wholesome attitude that is built up.[152]

During World War II, with the absence of many doctors overseas, the midwifery work done by nurses increased again, and in 1944, a course was finally begun to train "maternity nurses" in Canada. The course, given by the Unversity of Alberta School of Nursing, initially accepted only public health nurses, then widened its scope to admit nurses working in small rural hospitals. The program was spread over three months and was called "Advanced Practical Obstetrics." In 1967, a second program was started at Dalhousie University, for nurse practitioners, offering a thorough training in midwifery. The head of this program, Ruth May, had taken her midwifery training with the Frontier Nursing Service in Kentucky. Although never formally accredited by the British Central Midwives' Board nor by the American College of Nurse-Midwives, the two-year Dalhousie program, with its intensive northern internship, was the closest thing Canada had to its own midwifery school.

In 1978 a third program — this one straightforwardly named "Nurse-Midwifery" — started up at Memorial University in Newfoundland.

The establishment of these programs reflected a development that had been building in the northern parts of all provinces and in the Northwest Territories since the late 1950s. At the end of the 1950s, the Medical Services Branch of Health and Welfare had considerably enlarged its staff of nurses and physicians in an effort to do battle with tuberculosis among native Indian and Inuit people. This objective was then expanded to include the delivery of all types of modern medical service, including childbirth. Moving childbirth out of the tents and the igloos was a gradual process, limited both by the cost of increasing medical facilities and by the reluctance of native people to abandon their birth culture. Some of the medical workers sent up to the north were ambivalent about the government's aims. Dr. Otto Schaefer, a physician who began with Medical Services in 1952, recalls the beginnings of the program:

> We only slowly got involved in midwifery. There was a push from above for more hospital deliveries, and deliveries in nursing stations instead of in tents and igloos. I do not say that I was one hundred per cent convinced that there was such a great need for it, but eventually it was inevitable.[153]

Dr. Schaefer was not convinced of the need for such a fundamental change in the native birth culture because, in his experience, the number of complications in hunting camp deliveries, still handled by the native midwives, didn't seem to be higher than in the births handled by the nurses. There were, however, only limited attempts to evaluate mortality and morbidity data prior to the implementation of the new policy, since it was regarded as axiomatic that any move in the direction of medicalized birth would be a move towards better health.

The nurses who came to work in the North therefore began to persuade the local women to be delivered at the nursing stations. This seems to have happened gradually and with a growing respect on both sides. At the beginning, Medical Services had a policy stating that if a nurse-midwife were called to a birth where a native midwife was already working with the mother, the nurse-midwife was to act as a back-up rather than to take over. If a nurse-midwife won the respect of the local women, she might find that they gave her help, unasked for, not only in persuading pregnant women to come to prenatal clinics, but also in helping with births when there were too many for the nurse-midwife to handle.

> One night in February, I'd had a whole slew of patients, in fact I'd had a delivery every day. And I was really exhausted. The midwife walked in that night about ten o'clock, and she said: "you sleep, I'll work"... I made a mistake. I insulted her that night. I really felt bad about it after. I made the mistake of showing her how to check the woman post-partum — "turn her over and look underneath her." I'll never forget the look in this midwife's eyes and face when I said that. She was so insulted. And I thought — she's actually been a midwife for thirty years and I'm telling her how to check the postpartum patient — you know, it was absolutely ridiculous on my part. Anyway she forgave me. And I went off to bed and she stayed up all night with the patients and the babies. Everything was fine. And then after that if I had a delivery in the daytime or if I'd been up most of the night with a labouring patient, then she'd come that night and sit. It just got to be routine. I'd say to her, "Marion, you know there's three ladies who might go into labour, eh? I'm going away today. You look after them while I'm gone." And she always did a beautiful job — no episiotomy, no tear.[154]

The etiquette of the relationship between traditional midwife and nurse-midwife obviously took some delicate working out. The nurses also had to learn to handle the placenta with respect and to be mindful of the role that birth played in the life of the communities.

Nurse-midwife Jo Lutley, who arrived in 1961 from England and came to Medical Services after a stint with the Grenfell Association, found that some of her routines from home were inappropriate in this new, isolated setting. A physician who had worked in Africa for many years gave her some valuable advice: "Do not listen for the baby's heartbeat," she told Lutley, "since in an isolated situation you could take little dramatic action if you heard problems. Instead, focus your attention on the mother. If you do as much as you can to support the mother during her labour, then the baby will do as well as possible."[155]

In centring her attention on comforting and encouraging the mother, Jo Lutley behaved rather like the traditional birth helpers that existed before medical birth arrived. She did more than that, of course — she gave prenatal instruction, vitamins and extra food vouchers. She sent women whom she evaluated as high risk out by air transport prior to their due dates. This included first-time mothers with breech babies (she felt confident in delivering breech babies in women who had given birth before, as did the native midwives) and women with very poor health or poor obstetrical histories. Of perhaps 100 mothers seen prenatally in a year, she would transport four or five. Nurse Lutley had forceps with her but never had occasion to use them. During her entire time working in the north she lost neither a mother nor a baby at birth (one baby was dead before labour began). Her most dramatic recollection was of a mother who began to bleed heavily three weeks before her due date, an indication of placenta praevia (the placenta is positioned partly over the cervix, and often begins to bleed in late pregnancy). She was able to make telephone contact with a doctor at Moose Factory who advised rupturing the membranes. In fear and trembling, Lutley and a Scottish midwife did this, whereupon the baby's head descended, the bleeding stopped, labour shortly began, and the woman was delivered of a healthy baby.

Reports from Medical Services workers like Jo Lutley who worked in the north at this time suggest that the midwifery system they had created may have been very successful. In order to increase the skills of the Canadian nurses without midwifery certificates who were working at the nursing stations, Medical Services created a program called "Clinical Training for Northern Nurses." Starting in 1969, it consisted of four-month courses offered at six medical schools, from Edmonton in the west to Sherbrooke in the east.[156]

As the nursing stations multiplied, traditional midwives came to be replaced almost everywhere by nurse-midwives. There was a gradual shifting of policies. Women who were having their first baby, and those who had already borne five children or more, were added to the high risk group and transported to base hospitals (for example, at Churchill, Moose Factory, Sioux Lookout, Goose Bay, St. Anthony or Yellowknife) or to large urban hospitals if they seemed potentially very high risk. There was a strong reaction to this change in policy from the native people at the beginning.

> The native population at first objected very much to the transports, because there was a breakdown of families caused by several months' absence, often. There were perhaps other children at home, not properly looked after. I have personal knowledge of a house burning down in Spence Bay, with the other children in it, while a mother was awaiting delivery in Yellowknife. I know of cases where either one or the other partner acquired V.D. during that time.[157]

The long separation of families resulting from the evacuation of more and more pregnant women was seen as being very disruptive to family and community life. To demonstrate to the community the need for the transports (and to demonstrate to those at Medical Services who wished to evacuate everyone the safety of delivering "low risk" mothers at nursing stations), the Northern Medical Unit of the Manitoba School of Medicine undertook a five-year survey of perinatal mortality in the Keewatin area of the NWT from 1971-75. Despite the fact that one third of the births during that time took place in isolated nursing stations, the perinatal mortality in the Inuit group turned out to be only slightly higher than that of the Canadian population as a whole. What was more, over half the mortality was of premature infants (who would have been born in the settlements even if there had been a policy of 100% evacuation at the end of pregnancy). There were no maternal deaths.

These were the conclusions of the study:

> In the context of modern obstetrics in the western world it is difficult to defend patients delivering their babies in isolated areas without medical help or hospital facilities. In the present social and cultural context of the Canadian Inuit, however, this still seems to be desirable. The maternal and perinatal results of this five-year survey seem to support this.... These results are due to experienced midwives (to whom the main credit must go), a liberal evacuation policy, close general practitioner involvement, and a specialist visiting and consulting service. Any reduction in the level of these services would be potentially disastrous....[158]

As Dr. Thomas Baskett has written, even with satisfactory results it was hard to defend deliveries by midwives in isolated areas. Another survey over the next five years showed similar results.[159] But this evidence could not prevail against the dominant birth culture, which was based on the a priori knowledge that hospital birth was safest. Therefore the policies of both the Medical Services Branch and the Grenfell Health Service in Newfoundland/Labrador continued to move in the direction of total maternal evacuation. A number of factors helped to hasten this process. Immigration laws were tightened and it became more difficult to bring British or Australian midwives into the country. Canadian nurses, even when given the "clinical training" course, lacked confidence that they could handle births. The system of supportive obstetricians and doctor visits to the nursing stations crumbled. An Irish midwife formerly working in Labrador, Mary Stevenson, observed that as the policy of total evacuation became more pronounced, the nurses became more nervous about doing low risk deliveries, even when their results were excellent. Stevenson felt that there came to be an atmosphere of crisis around birth.[160] Many of the nurses were young and inexperienced. (The average age in nursing stations around Sioux Lookout was 22; the average stay in some areas was less than one year). They were less willing than the midwives from Great Britain or elsewhere had been, to be on call 24 hours a day and to work the extra hours required of them when there was a maternity patient at the station. If a mother did go into labour before she could be sent out, it was not uncommon for the nurse to send her to hospital, together with her baby, on the next flight out, so that the postpartum care could be handled elsewhere.

The reduction in births at the nursing stations also resulted in a real diminution in the competence of the nurses, since they now had very little chance to deliver babies. In many ways, then, the policy of considering birth as too dangerous to take place with midwives outside of hospital became a self-fulfilling prophecy.[161]

Canada's rather wide-ranging attempt to install a safe midwifery system across the north has now crumbled into remnants. Reaction from the native population has been varied, ranging from acceptance, to specific complaints about hospital procedures, to a more general rejection of evacuation. The rejection seems to be most pronounced among Inuit people and is apparently leading some Inuit women once again to avoid prenatal care, and in some extreme situations to run and hide when the plane comes to fly them out. Evacuation has become an important political issue in some communities.[162] In these communities, nursing stations are staffed with nurse-midwives who, counter to the official policy of 100% evacuation, do deliver the babies of women who refuse to leave. If the determination to avoid evacuation spreads, it is unclear how Medical Services can respond. One of the reasons for the dismantling of the nursing station births was the difficulty of finding competent nurse-midwives who would wish to work so far from home, and who would stay there long enough to build a relationship with the local people. This problem has bedeviled nursing organizations from the beginning. As soon as the Victorian Order of Home Helpers gave up its intention of training "local women, already respected by their communities," its new incarnation, the Victorian Order of Nurses, started on an endless process of trying to keep its nursing posts staffed with nurses — women who were often overwhelmed by the isolation and strangeness of a totally different culture. This problem has never gone away.

In response to government organizations that tell the Inuit that nursing-station deliveries are a thing of the past, some native people are calling for a return to the local midwife, who is part of the community and will not leave after half a year.

> The people are fighting back. They're saying, "We've done it for generations and we can do it ourselves." But if we wait much longer, the people will forget how to do it, and it will be too late.[163]

There are some non-native health workers who also believe that native midwifery ought to make a return. In an unusual experiment in a hospital in Povungnituk, near Hudson's Bay, the maternity "team" of the maternity unit consists of several non-Inuit doctors, two non-Inuit nurse-midwives and five Inuit birth assistants who attend births and also take part in all treatment decision meetings, where they have, theoretically at least, influence equal to the medically trained members of the team.[164]

CONCLUSION

When supporters of medical childbirth set out at the beginning of this century to make a clean sweep of the existing birth culture and to begin afresh, some of them were inspired by the profound belief that they were creating a birth system more perfect than any that had been devised in human history. And indeed, during the course of this century, the proportion of mothers and infants who did not survive childbirth diminished wonderfully.

How much of this improvement in childbirth mortality and morbidity can be attributed to the predominance of medical childbirth remains unclear. What is clear is that the conclusion that undoctored birth was very dangerous came before there was any evidence on the subject. In fact when the evidence was compiled, it showed that doctored birth was no safer. One would have to say, therefore, that the foundations of obstetrics in this country were based, not on science, but on belief.

Decades of persistent public education went into the effort of gaining public acceptance for medical birth. By the end of this period, the traditional birth culture had largely lost its legitimacy, and childbirth had disappeared from the community and the family into a new environment created by the expanding professional groups of medical workers.

Toward the end of the 1950s there was increasing public awareness of how much childbirth had come to be seen and treated as an unnatural event. Reformers, inside and outside the hospitals, set about trying to restructure the birth process so that it would be more satisfying for the woman, more involving for her partner, and more gentle for her baby. There came to be a renewed interest in the midwife and in her capacity to help make childbirth more congenial.

Attempts to annex the midwife to the medical birth culture may, however, be difficult. The midwife was intimately a part of the traditional birth culture, and much of her way of working reflected the elements of traditional birth that disappeared during the ascendancy of modern obstetrics. How well she can function in an environment that recognizes her but not the tradition from which she arose is a puzzle.

It may be that, in order for the midwife to have a significant role to play in maternity care at this time, both modern obstetrics and childbirth reformers will need to take a careful look at the details of the popular birth culture that persisted in this country until the first of this century. Many of the elements of the original birth culture may be shown, on reexamination, to be sound, and to be worth taking up again along with the midwife.

Notes to Appendix 1

[1] Charlotte Hanington, "Maternity Care in Canada", address to the National Council of Women, Annual Meeting, 1923, *National Council of Women Yearbook, 1923.*

[2] William B. Hendry, "Maternity Welfare", address to the Annual Meeting of the Canadian Medical Association, 1931. Reprinted in *Social Welfare*, June 1931.

[3] John T. Saywell, ed. *The Canadian Journal of Lady Aberdeen, 1893-1898*. Toronto Champlain Society, 1960, p.35.

[4] Maude Abbott, *The History of Medicine in the Province of Quebec*, McGill University Press, Montreal, 1931.

[5] John Murray Gibbon, *Three Centuries of Canadian Nursing*, in collaboration with Mary S. Mathewson, MacMillan Co., Toronto, 1947.

[6] R. MacKay, "Poor Relief and Medicine in Nova Scotia, 1749-1793", in S.E.D. Shortt, ed. *Medicine in Canadian History: Historical Perspectives*, McGill University Press, Montreal, 1981.

[7] Richard W. Wertz, Dorothy C. Wertz, *Lying-In: A History of Childbirth in America*, Schocken Books, New York, 1979, p.20.

[8] Robert Gourlay, *Statistical Account of Upper Canada, Vol. 2*, S.R. Publishers Ltd., Johnson Reprint Collection, 1966.

[9] Audrey Saunders Miller, ed., *The Journals of Mary O'Brien 1828-1838*, Macmillan Co., Toronto, 1968, p.231.

[10] Miller, *op. cit.*, p.234.

[11] Anna Brownell Jameson, *Winter Studies and Summer Rambles in Canada. Selections*, McClelland and Stewart Ltd., Toronto, 1965, (First pub. in 1838), p.123.

[12] A.F. Van Wart, "The Indians of the Maritime Provinces, Their Diseases and Native Cures", *Canadian Medical Association Journal*, 59, pp. 572-577, 1948.

[13] Jameson, *op. cit*, p.123.

[14] Dr. Otto Schaefer, formerly of Northern Medical Research Unit, Medical Services Branch, Health and Welfare Canada; interviewed in Toronto, October 24, 1986. Also: Otto Schaefer, M.D., "Pre- and Post-Natal Growth Acceleration and Increased Sugar Consumption in Canadian Eskimos", *CMAJ*, November 7, 1970, Vol. 103, p.1059 ff.

[15] Dr. Otto Schaefer, interviewed October 24, *op. cit.*

[16] George E. Darby, M.B., Medical Superintendent of R.W. Large Memorial Hospital, Bella Bella, "Indian Medicine in B.C.", *CMAJ*, April 1933, p.438.

[17] Rita Dozois, Medical Services Branch, interviewed for "Doctoring the Family," CBC Radio *Ideas* series, prepared by Jutta Mason and David Cayley. Broadcast on CBC April 4-25, 1985. Transcript published by CBC Transcripts, Montreal, 1985.

[18] Jo Lutley, Medical Services Branch, interviewed for "Doctoring the Family," *op. cit.*

[19] Dr. Otto Schaefer, *op. cit.*

[20] Wm. B. Howell, *F.J. Shepherd—Surgeon, His Life and Times*, J.M. Dent & Sons, 1934.

[21] Cecilia Benoit, in her article "Midwives and Healers: The Newfoundland Experience" (*Healthsharing*, Winter, 1983, p.22) tells about one midwife, Aunt Mary-Ellen, who attended more than 500 births in her area.

[22] Anonymous, *Reflections on Our Heritage, A History of Steinbach and the R.M. Hanover from 1874.* printed and published by Derksen Printers Ltd., Steinbach, Manitoba, 1971. (Available at University of Manitoba Medical Library.)

p.218: "Aside from chiropractors, most Mennonite settlements had midwives whose duties involved not only assisting at the actual births but taking over the household duties until the mother was strong enough to do them herself. Families were much larger in the early days and some midwives would stay for ten days. Fees were adjustable to circumstances... Mrs. Abram Eidse started her career because doctors were unavailable. Her husband helped her by ordering books and the two were considered to be a very gifted, intelligent couple. They were both well-read and took responsibility in trying situations... Frau Reichel was both herb doctor and midwife. She came over from Hungary where she had received her training... Mrs. John Fillinger, a sister to the late Bishop of Blumenort, practised as a midwife for thirty years...."

[23] M. Miyazaki, *My Sixty Years in Canada*, private printing, U.B.C. Woodward Memorial Room.

p.11: "In my general practice [1930s, Vancouver] I did not handle too many maternity cases because most Japanese people depended on Japanese midwives, Mrs. Tanabe, Takahashi, and Watanabe, well-trained midwives from Japan but who had no license to practise in B.C. So they called themselves maternity helpers. They could not send a bill but accepted whatever amount the patient gave them. Mrs. Watanabe was operating a rooming house so that Japanese women from the West Coast and country used to come to Vancouver a week before the expected date and stayed at her rooming house where Mrs. Watanabe delivered the baby and took care of the mother and baby. Mrs. Tanabe had more business than the others... she was homely looking but very much liked because she helped wash the diapers after she bathed the baby. I was called whenever these women had difficult cases."

[24] Sometimes these books were very specific and detailed, as for example Edouard Moreau's *Instruction sur l'Art des Accouchements, pour les Sages-Femmes de la campagne*, De l'Imprimerie de Fabre, Perrault & Cie, Montréal, 1834. (Available at Toronto Central Reference Library). An English language example is Thomas Hersey's *The Midwife's Practical Directory*, Baltimore, 1836. The name on the flyleaf of this book, found at the Thomas Fisher Rare Book Room of the University of Toronto, is Hannah L. Hitchcock, who might have been a midwife or may just have been a married woman who found it useful to be precisely informed about birth technique, both for herself and for her friends when she was called to help them. The descriptions in the book are so detailed and explicit that they would still be useful today to guide a midwifery student. An example, about the third stage of labour, the birth of the placenta:

p.164: "The woman having rested a few minutes, apply the hand to the abdomen, a little below the navel, over the hypogastric region, and the hard globular figure of the contracting womb may be perceived. If there be no commotion, gently drawing with undulating or rotatory motion of the cord, and pressing one's hand on the abdomen from the belly downwards, or an assistant pressing gently on her sides, will excite action. Much benefit often arises by raising the woman to her feet, or placing her on her knees, in which position children are often born. The natural weight of the placenta will facilitate its descent.

The inexperienced practitioner cannot be cautioned too often not to make any violent efforts, because breaking the string from the placenta might be attended with disastrous consequences."

Whether or not they owned one of these very explicit midwifery manuals, there were few families who did not have an all-purpose medical book, often including veterinary and cooking sections, but also provided with detailed anatomical charts of the human body. In many pioneer households these books seem to have been freely available for inspection even to the children of the family.

Somewhere between the very precise midwifery manual and the all-purpose "doctor book" were the very popular women's manuals, such as Pye Henry Chavasse's *Advice to a Mother on the Management of Her Children* (1880), and *Advice to a Wife on the Management of Her Own Health* (1879), and P.B. Saur's *Womanhood* (1885) (parts of which match Chavasse's book word for word). While these books mainly dealt in kindly, wholesome advice of a general nature, there were some passages that contained specific and potentially very helpful birth information. An example from *Womanhood*:

p.233 "[If the newborn doesn't breathe despite stimulation], let the nurse close with her left hand, the child's nose, to prevent any passage of air through the nostrils; then let her apply her mouth to the child's mouth, and breathe into it, in order to inflate the lungs; as soon as they are inflated, the air ought, with the right hand, to be pressed out again, so as to imitate natural breathing. Again and again, for several minutes and for about fifteen times a minute, should the above process be repeated; and the operator will frequently be rewarded by hearing a convulsive sob, which will be the harbinger of renewed life."

[25] Hilma Brekkaas, homesteader, Peace River Valley, interviewed at her home May 17, 1979, Summerland, B.C.

[26] Public Archives of Canada, Maternal Welfare Council Archives, Vol. 99, File 499-3-2, pt.3, undated (probably 1930s).

[27] Clara Anne Tarrant, Newfoundland midwife, interviewed for CBC Radio, 1979, CBC Tape Archives, 750514-8.

[28] B.J. Banfill, *Labrador Nurse*, Ryerson Press, Toronto, 1952, p.82. See also "The Nature of Puerperal Fever" Editorial, *Canada Lancet*, 1896, p.371.

[29] A.D. Blackader, M.D., "Thoughts on Maternal Mortality", *CMAJ*, 1929, p.656.

Also E.W. Montgomery, M.D., Minister of Health and Public Welfare, "Maternal Mortality", *Canadian Public Health Journal*, Vol. 21, 1930, p.219.

[30] Cecilia Benoit, interviewed for CBC series "Doctoring the Family," *op. cit.*

[31] Mrs.Lillian Miles, Edenwold, Saskatchewan, Saskatchewan Archives Board, Pioneer Questionnaires (Health), SX-2.

[32] H. Gordon Green, *Don't Have Your Baby in the Dory: A Biography of Myra Bennett*, Harvest House Ltd., Montreal, 1974.

[33] Janie Dennison Nichols, midwife in Baddeck, N.S. from 1904. Interviewed by K. Moggridge, 1978.

Interview with Mr. Neill Coutts, May 18, 1979, Summerhill: Mr. Coutts, then aged 80, said he could remember only one baby dying during his youth in frontier Saskatchewan, and that baby was premature. He could remember no mother dying in childbirth in his area. "People were lucky, or maybe they were tougher than today."

Dr. C. Lamont MacMillan, author of *Memoirs of a Cape Breton Doctor*, (McGraw-Hill Ryerson, Toronto, 1975) when interviewed by sociologist Kathy Moggridge in 1978, told her that in his own practice, during which he attended about 2000 births, he lost two mothers and "not many" babies. In his opinion, infant mortality had always been very low in the areas of rural Cape Breton where he practised.

There must have been other rural or isolated areas where mortality was high. In the absence of detailed statistical records, however, it is interesting to note how closely responses match when older people are asked about birth mortality in the frontier areas of their youth. The majority of respondents whom I interviewed in three trips across the country painted a much more positive picture than I had been led to expect from commonly held assumptions about unmedicalized birth.

[34] "I made a compilation of some statistics regarding [maternal mortality] in Saskatchewan a few years ago, and the results were not at all favourable. They were such that I did not think it would have been well to give them to the public... I mentioned the results of this compilation... at a meeting of the Saskatchewan Medical Association and I was very strongly taken to task by some of the members for even compiling these figures. I told them I thought the proper place to give these figures was to a meeting of medical men. I was taking care that they were not being published."

Source: Dr. M. Seymour, Medical Officer of Health for Saskatchewan, speaking at a meeting of the Maternal Health Committee of the Dominion Council of Health, 1919. Cited by Leslie Biggs in *The Response to Maternal Mortality in Ontario, 1920-1940*, unpublished Master's thesis, University of Toronto, 1983, p.113.

[35] E.W. Montgomery, M.B., Minister of Health for Manitoba, "Maternal Mortality," *Canadian Public Health Journal*, Vol. 21, 1930, p.219.

[36] From: Red Cross Archives File, Red Cross House, Toronto. Correspondence between Mrs. C.B. Waagen, Honourary Secretary of the Committee on Policy, and Dr. Fred Routley, Director of the Ontario Division of Red Cross.

[37] Dr. Fred Routley to Mrs. C.B. Waagen, February 24, 1928, Red Cross File, *op. cit.*

[38] "*Meddlesome Midwifery,*" *Editorial, Canada Lancet*, September 1885, p.26.

[39] W.A. Bigelow, *Forceps, Fin and Feather. Memoirs of Dr. W. A. Bigelow*, D.W. Friesen & Sons Ltd., Altona, Manitoba, 1969.

[40] Jo Lutley, Medical Services Branch, interviewed for CBC Radio series "Doctoring the Family," *op. cit.*

[41] Mrs. Alexena Marion, pioneer from 1910 at Macoun, Saskatchewan. Saskatchewan Archives Board, Pioneer Questionnaires (Health), SX-2.

[42] Violet MacNaughton, Report sent to Canadian Nurses' Association, n.d. At: Saskatchewan Archives Board, The Papers of Violet MacNaughton.

[43] Mrs. Alexena Marion, Pioneer Questionnaires, *op. cit.*

[44] For example: J. M. Penwarden, M.D., "Barbarous Treatment by a Midwife", *Canada Lancet*, Feb. 1872, p.273. The midwife had torn off two arms of a wedged baby, which was already decomposing when the author was called. With the help of another physician, the author anaesthetized the mother and removed the baby. There is an even more tragic ending to the story. The doctor, having frightened the midwife away with threats of arrest, left as well, after he had delivered the baby. The accustomed role of the neighbour woman—to help clean up the mother and take care of the household after the birth—was therefore not taken by anyone. On the second night after delivery, the husband went out and got drunk. When he came home, he "told her he would kill her if she did not get up and clean herself. Being very much frightened she got up on the floor, changed her clothes, and feeling faint, laid down and immediately expired."

The doctor felt that he had done well to uncover this barbarous midwife. The moral? "...it teaches us the absolute necessity of keeping our lying-in patients in the horizontal position, till all danger of fatal syncope or formation of clots in the heart is passed."

[45] Thomas Hersey, *op. cit.*, p.215.

[46] *Ibid.* p.227.

[47] M. Alcock, Reeve, Rural Municipality of Hazel Dell, Saskatchewan. Letter dated June 15, 1927. At: Saskatchewan Archives Board.

[48] The first medical school in Canada was established at McGill in 1829. After teaching privately for many years, Dr. John Rolph established the Toronto School of Medicine in 1843. By 1850 two more schools had begun in Quebec, and two more in Toronto. By 1883, there were also medical schools in Kingston (Queen's), Lennoxville P.Q. (Bishop's), Halifax, London Ontario, (Western), Winnipeg (University of Manitoba) and two more specifically for women—at Kingston and Toronto. William Osler, *The Continuing Education*, (ed. by John P. McGovern and Charles G. Roland), Thomas Publishing Co., Springfield, Illinois, 1969.

[49] A.D. Blackader, "Maternal Mortality", *CMAJ*, 1929, p.656.

[50] Robert Gourlay, *op. cit.*

[51] Leslie Biggs, "The Case of the Missing Midwives. A History of Midwifery in Ontario 1795-1900," *Ontario History*, LXXV, Issue 1, 1983, pp. 21-35.

[52] 55 George III, c.10 (U.C.)

[53] 29 Vic. C34 (Can).

[54] *Dominion Medical Journal*, August, 1869.

[55] Letter to the Editor, *Canada Lancet*, Vol. 6, 1873-74.

[56] Manitoba Archives, College of Physicians and Surgeons of Manitoba, Correspondence File, MG10 A15.

[57] *Ibid*, letter from Mrs. K. Bell, Belmont, December 25, 1899 to Dr. Gray, Registrar.

[58] *Ibid*, letter from Dr. Jones to Dr. Gray, January 9, 1895.

[59] *Ibid*, letter from Mr. Campbell (lawyer) to Dr. Gray, June 20, 1895.

[60] *Ibid*, letter from Minnedosa, Manitoba June 5, 1887:

"...there is quite a strong feeling in Mrs. Towers' favour down here to allow her to practise midwifery. But you generally see it the case with the public, they think that it is more of a persecution than a prosecution."

[61] Queen vs Whelan, 1901. Criminal Court Case: 4, pp. 277-283.

[62] Leslie Biggs, "The Case of the Missing Midwives", *op. cit.*, p.24.

[63] *The Hamilton Times*, July 17, 1915. More information on this case is found at the Ontario Archives, Attorney General's Correspondence, RG4 series C-3 (4-31) 1915, No. 1472.

[64] Manitoba Archives, College of Physicians and Surgeons of Manitoba, Correspondence File, *op. cit.*

To a considerable extent, the struggle between the doctors and the popular birth culture may have been the result of the recent arrival of many of the doctors. Having fewer personal connections with the farmers in their adopted communities, the doctors fell back on the law to force their way in. Some doctors who had come to feel part of the community were much less critical. Here is a letter from a Dr. McFadden to the Registrar, about the same Mrs. Long:

"I may say... that I have been practising here since 1882 and have had no trouble with Mrs. Long or any other person interfering with midwifery cases. I am aware that she (Mrs. Long) acts as a nurse and I may say is indeed a very useful person as such.... Her people are good patrons of mine and I do not wish them to suppose for one moment that I had anything whatsoever to do with you writing her threatening prosecution."

College of Physicians and Surgeons, Correspondence File, Manitoba Archives MG10, A15. Letters from Dr. J. J. McFadden, Neepawa, Manitoba, February 1 and February 14, 1891.

[65] Dr. Benjamin Atlee, interviewed by Kathy Moggridge, Halifax, 1978.

[66] Public Archives of Canada, The Victorian Order of Nurses, MG 27, I B5, Vol. 10, Memorandum to Montreal Local Council of Women, 1897.

[67] *Ibid.*

[68] *Ottawa Citizen*, June 4, 1897.

[69] Public Archives of Canada, Victorian Order of Nurses, MG 27 I B5 *op. cit.*, Vol. 6, letter from Nora Livingston to Lady Aberdeen, February 20, 1897.

[70] Ishbel, Lady Aberdeen, *The Canadian Journal of Lady Aberdeen*, original manuscript, Public Archives of Canada, MG27 I B5.

[71] *Ibid.*

[72] Aberdeen and Temair, John Campbell Gordon, First Marquis of "*We Twa:*" *Reminiscences of Lord and Lady Aberdeen*, Vol. 2, W. Collins and Co. Ltd., London, 1926.

[73] *Ibid*, p. 121.

[74] John Murray Gibbon, *The Victorian Order of Nurses for Canada. Fiftieth Anniversary, 1897-1947*, published by the Victorian Order of Canada, Montreal, 1947.

[75] Public Archives of Canada, Victorian Order of Nurses, MG 27 I B5 Vol. 4, Aberdeen Correspondence File, letter from James Robertson to Lady Aberdeen, June 14, 1897.

At the very darkest time of the organization of the VON, Prof. James Robertson, the Dominion Minister of Agriculture, wrote to Lady Aberdeen:

"The scheme lags in Toronto. The mayor wrote me a thoroughly forlorn letter the other day... The public have been well informed of the nature and objects of the movement; and if they do not subscribe as fully and generally as was expected, the educational campaign has not been without a deal of value in the community."

The educational campaign presumably consisted of making people aware that their situation was dangerous unless they had trained nurses to look after them.

[76] H.L. Burris, *Medical Saga; the Burris Clinic and Early Pioneers*, private printing at UBC Woodward Memorial Room, p.82, "Fourth year students were required to attend six obstetrical deliveries. All of us did so. Only one of those I attended was an instrumental delivery and I saw no maternal, pre- or post-natal complications. I never in this or any other service gave an anaesthetic." Dr. Burris took his medical education in Toronto in 1904. The deliveries he did watch, he watched at a distance, since medical students were never asked to participate nor were they tolerated close by.

When Dr. J.W. Williams of John Hopkins University Medical School did a nationwide survey of the obstetrical teaching in American medical schools in 1911, his findings suggested the situation had not changed since Dr. Burris' time.

"In the best situations a graduate might have attended thirty births. In most, he had attended none or one. Williams believed that no graduates could handle difficult labours, even if they could recognize them..."

From R. Wertz and D. Wertz, *op. cit.*, p. 146.

[77] W. A. Bigelow, *Forceps, Fin and Feather: Memoirs of Dr. W. A. Bigelow*, D. W. Friesen and Sons Ltd., Altona, Manitoba, 1969, p.53.

[78] One doctor attended 2,196 maternity cases with no deaths.
One doctor attended 2,300 cases with no death.
One doctor had no maternal deaths in 10 years.
One doctor had one maternal death in 33 years.
One doctor had one maternal death in 35 years.
One doctor had one maternal death in 37 years.

Helen MacMurchy, M.D. *Maternal Mortality in Canada, Report of an Enquiry made by the Department of Health*. Dept. of Health, Ottawa, 1928.

The debate about the use of forceps and other obstetrical interventions was longstanding and tended to be divided along rural versus urban lines until after World War I. In 1885 the *Canada Lancet* asked its readers the question—should forceps be carried to every labour case? Dr. R. W. Clark from Hastings, Ont. wrote to say that in a practice of 55 years he hadn't used forceps a dozen times. In that length of time he'd had only two fatal cases, "and those from puerperal fever and peritonitis." He reported that he had once been called to a case where the doctor was going to use forceps after being with a woman for two nights and two days. It turned out she was having false labour "which a full dose of laudanum checked." She was delivered ten days afterwards "of a fine child without forceps." He said he therefore could not agree that the forceps should always be carried, "for the proportion of cases really requiring instrumental aid are so few, that to carry them always entails a deal of unnecessary trouble."

[79] Nova Scotia Pharmaceutical Society, *Fifty Years of Pharmacy in Nova Scotia, 1875-1925*. At: Halifax Archives.

[80] Public Archives of Canada, The Victorian Order of Nurses, MG28/I 171, Vol. 7, Reports on Branches File, Ottawa, 1908. And in the Halifax report: "In 1905 it seems that the nurses found themselves called upon to attend many deliveries of poor patients who had no doctors engaged."

[81] *Op. cit.*, Reports on Branches File, Hamilton, 1903. A special meeting was called to consider this question.

[82] Public Archives of Canada, Victorian Order of Nurses, MG28 I 171, Vol. 3, Executive Committee Minutes, November, 1908.

[83] Although the first federal public health department was the result of much lobbying by the National Council of Women, when the department was established it gave no representation to the NCW. Called the Dominion Council of Health, it was composed of 14 male doctors, one male agricultural representative, and one female patriotic worker. In response to public disapproval about this composition, a new council was appointed. It consisted of all the provincial medical officers of health, a female social service and welfare worker, a female Women's Institute representative, a Quebec cattle breeder, and the president of the Trades and Labour Council of Hamilton.

So the volunteer women's groups had to continue to press their views on maternity care from the outside, for the most part.

[84] Report from the Special Committee on Maternal Care at the National Council of Women Annual Meeting, 1930:

"There are few voluntary organizations which have not held meetings to discuss the reduction of the maternal death rate; and the Press has assisted the campaign by magazine articles and newspaper items.

The public opinion thus generated has made possible the establishment of prenatal clinics and the engagement of a vast number of Public Health nurses under official and voluntary supervision. There is a movement in favour of adequately paid, full-time medical officers of health and county health units. Maternity wards have been improved, accommodation therein increased."

National Council of Women Yearbook, 1930. p.124.

[85] Mary Ard Mackenzie, "Canada and Midwives." *Women's Century Magazine*, January, 1918.

[86] When the National Council restored its nursing committee ten years later, now called the Committee on Maternal Welfare, it spoke wholeheartedly in favour of modern obstetrics.

"We must demand that medical and nursing schools shall [give better obstetrical training] realizing, as one British doctor remarked recently, that childbearing has ceased to be a simple physiological process; obstetrical practice demands the technique of modern surgery."

Mrs. H. P. Plumptre, Convener of the Committee on Maternal Welfare, speaking at the National Council of Women's Annual Convention, 1930.

National Council of Women Yearbook, 1930, p.125.

[87] Bertha E. Hall, "Must 1532 Women Die?" *Chatelaine Magazine*, July, 1928.

[88] Ethel Cryderman, "Prenatal Work," *Canadian Nurse*, 1927, Vol. 23, p.536.

[89] Department of Public Health, Toronto, *The Care of the Infant and Young Child; The Expectant Mother*, p.5, Department of Public Health, Toronto 2. At: Municipal Archives, Toronto.

[90] Helen MacMurchy, M.D. *The Canadian Mother's Book* (Little Blue Books, Mother's Series No. 1), Dept. of Health, Ottawa 1927, Publication #2 of Confederation Diamond Jubilee edition, p.24.

[91] Public Archives of Canada, Department of Health, R.G. Vol. 991, File 499-3-2 (pt. 3). Letter from Mrs. Leonard Renaud, Wawbewawa, Ontario, to the Department of Health, Ottawa, July 10, 1935.

[92] In an analysis of maternal deaths among women cared for by the Red Cross from 1920-1936, nursing supervisor Isabel Stewart admitted that almost one-third (4 out of 14) might not have died if they had stayed at home. Two had influenza and two had pneumonia at the time they died. Rather than stay home to give birth they travelled long distances in bad weather to get to the Red Cross hospitals. "The long drive in winter may have increased the burden on a lowered resistance." They came to the hospital because they had been told that birth was dangerous without medical attendance and so "fear entered their minds."

Isabel Stewart, "Obstetrics in Rural Saskatchewan," *CMAJ* April, 1936.

[93] Mrs. Leonard Renaud, *op. cit.*

[94] Public Archives of Canada, The Victorian Order of Nurses, MG 28 I 171, Vol. 3, Executive Committee Minutes, February, 1917.

[95] Public Archives of Canada, The Victorian Order of Nurses, MG 28 I 171, Vol. 6, letter from Mrs. Laidlaw to Dr. Gibson, September 6, 1917.

[96] Public Archives of Canada, National Council of Women, MG 28 I 25. Vol. 24, Minute Book 1913-1917, May 3, 1916.

[97] *Ibid.*

[98] Charlotte Hanington, "The Victorian Order of Nurses," *The Canadian Nurse*, November, 1918, p.1412.

[99] J. Clifton Edgar, "Why the Midwife?" reprinted from *Transactions of the American Gynaecological Society*, 1918.

[100] *Ibid.*

[101] *Ibid.*

[102] *Ibid.* Canada, of course, had no such deplorable situation in her cities. This was something to be thankful for. See for example:

W.W. Lailey, "The Progress of Maternal Welfare in the United States and Canada." *Canadian Journal of Public Health*, June, 1927, p.251:

"Canada has an advantage in having no negro or midwife problem, but otherwise conditions are similar in the two countries."

[103] J.C. Edgar, *op. cit.*

[104] H.M. Little, "Obstetrics During the Past 25 Years," *CMAJ*, October, 1924, Vol. 14.

p.904: "Not only is it evident that [our maternal mortality] is high, but it is well known that the cause is incompetent medical attendance, for maternal mortality is higher when the patients are attended by physicians than when they are attended by midwives. Indeed, Dr. William Nicholson of Philadelphia recently gave me statistics for the cases controlled by midwives in his district—20 deaths in 60,000 cases."

Dr. Little went on in the article to advocate routine episiotomy and routine forceps for first-time mothers.

[105] J.C. Edgar, *op. cit.*

[106] Charlotte Hanington, "Maternity Care in Canada," address to the National Council of Women Annual Meeting, 1923 (*NCW Yearbook*, 1923).

[107] *Ibid.*

[108] *Red Cross Annual Report, 1922*. At: Red Cross House, Toronto.

[109] *Red Cross Annual Report, 1933*.

[110] Public Archives of Manitoba, College of Physicians and Surgeons, correspondence file, MG10 A15, letter to Dr. J. Coulter, Registrar, College of Physicians and Surgeons of Manitoba, January 24, 1923, (copy, unsigned).

[111] Violet MacNaughton, President of the Women's Section of the Saskatchewan Grain Growers' Association, sent the Canadian Nurses' Association a description of the kind of conditions that made life miserable for a nurse working in the prairies: [probably sent in the early 1920s]

"Too often, the house consists of one room, if the weather is severe the new baby must be born practically in the presence of the family.

"Too often, no soft water, sometimes both mother and child have to wait while efforts are made to procure soft water.

"Too often, if the Nurse cannot do the maternity washing it must wait until the mother is able. Probably, she cannot change again till that washing is done.

"Too often, it is impossible to get anyone to look after the rest of the family. The cooking, etc., must all be done in one room with the patient.

"Too often, the nurse has to contend with peculiar and unsanitary prejudices on the part of the patient and friends, particularly if non-English speaking.

"Too often no suitable utensils for the nurses's use".

The fact that these conditions did not necessarily result in ill health is illustrated in this comment by Nurse B.J. Banfill:

"Most of my babies were delivered under adverse conditions, with semi-sterile technique, but none of the mothers developed any infection."

B.J. Banfill, *Labrador Nurse*, Ryerson Press, Toronto, 1952.

[112] Norma Philips Muir, "Need Birth Bring Death?" *Canadian Home Journal*, Vol. 18, May, 1934.

[113] Charlotte Hanington, speech given at NCW Annual Meeting June 26, 1923, *op. cit.*

[114] Margaret Duffield, "Maternal Care in Ontario," *Canadian Nurse*, Vol. 21, 1925, p. 259.

[115] Editorial, "Meddlesome Midwifery," *Canada Lancet*, 1896, p. 371.

[116] H. Farquharson, M.D. wrote an article in 1948 entitled "Hazards in the Use of Anaesthetics," in which he quoted a British researcher named Elam, who had demonstrated that the death rate from anaesthesia in Great Britain increased as additional agents and techniques had been introduced (H. Farquharson, "Problems of the Anaesthetist—Hazards in the Use of Anaesthetics," *CMAJ*, October, 1948, Vol. 59), p.317ff.

In another article in 1948 about continuous candal block, the writer promoting its use was unable to compare outcome between babies of totally unanaesthetised mothers and those whose mothers had candal anaesthesia. He quoted a study instead which showed that when 2500 deliveries with candal anaesthesia, averaging three hours duration, were compared with a control group "having the usual anaesthetics and sedatives," the control group had twice the infant mortality. This article illustrates the tendency that existed (and may still exist) in obstetrics, to discover the dangers of a drug or a technique just after a new drug or technique has been discovered to replace it. According to this author, candal anaesthesia was quite safe in all respects.

John Cleland, M.D., "Anatomical Basis for Continuous Candal and Other Forms of Regional Block in Obstetrics," *CMAJ*, September, 1948, Vol. 59, p. 225ff.

[117] L.J. Harris, "A Plea for Conservatism in the Use of the Caesarean Section." *CMAJ*, July, 1937, pp. 32-38.

In his article Harris deplored "...the host of articles that are being written by prominent obstetricians enthusiastically advocating caesareans for every obstetrical complication imaginable.... Plass estimates that there are 25,000 caesarean sections in the USA each year, with a maternal mortality of about 10 per cent. This is at least 20 times as great as the maternal death rate for vaginal deliveries. There is excellent evidence to show that about three quarters of these sections are not justified."

[118] J. Polak, M.D. "Controversial Points in Obstetrical and Gynaecological Practice," *CMAJ*, Vol. 21, 1929, p. 657.

"Another cause of our high fetal and maternal mortality is the popularity which has been given to painless labour by shortening the second stage by elective version. One of the enthusiastic advocates of this procedure reports in four successive years more than 900 hundred versions in about 1,100 deliveries. This, at first sight, rather staggers one, and when we look at the primary foetal and infant death rate during the first week of life we are more startled by noting that it is just four times the infant mortality throughout the remainder of the state where this fearless operator practices."

[119] In 1920 a "prominent physician" in a city in eastern Canada came into a maternity hospital to deliver a patient, showing "a boisterousness which wakened other patients...between 1:00 a.m. and 4:00 a.m." He was sufficiently noisy that he awakened a patient in a room 60 feet away. The head nurse afterwards confided to several persons, (including another doctor called in later to see the patient's dying infant) that the physician had been quite drunk at the time of the delivery. The physician took her to court for breach of privilege. The article reporting this "legal case of unusual interest" pointed out that:

"...no nurse is at liberty to criticize a physician, even though she may know that for one or another reason, he is incapable of properly caring for the case in hand... By speaking, she breaks 'the ethics of the profession' and risks not being allowed to earn a living."

The jury's verdict was to award $1.00 damages to the physician.

It was not only nurses who were gagged from speaking out by the code of "professional ethics." In an article about maternal mortality in 1936, Dr. K.M. Wilson reported that no one at that time felt they really had the authority to challenge doctors who had unusually high mortality.

"...what shall be done about the poorly trained men already in practice who are responsible for so much of the difficulty? To handle this situation properly will require a high order of moral courage on the part of a good many people... The man who turns in repeated death certificates on puerperal women should be held to strict accountability for his results, and somebody in authority should have the power to insist that such a one receive further training before continuing on his career. Professional ethics must not be used as a cloak to conceal incompetence."

K.M. Wilson, "Maternal Mortality," *CMAJ*, January, 1936.

[120] Stella Pines, R.N., "Making Ready for the New Arrival," *Chatelaine*, November, 1928.

[121] A.D. Blackader, "Thoughts on Maternal Mortality," *CMAJ*, June, 1929, p.656. Dr. Blackader also added some new information about puerperal sepsis which indicated that three centres that conducted births mostly at home and mostly with midwives had an enviably low record of deaths from infection.

"The extern practice of the Edinburgh Maternity Hospital shows a consecutive series of 5000 spontaneous births with only two deaths from sepsis; the East End Maternity Hospital of London has a record of 47,503 deliveries in an unselected practice among poorer classes with only five deaths from sepsis; the practice of midwives at the Queen Victoria Jubilee Institute during 1927 shows consecutively 53,502 deliveries with only six deaths from sepsis. This includes normal and abnormal cases."

By way of comparison, Montreal obstetrician J.R. Goodall wrote an article in the same year in which he chronicled the maternal mortality in the U.S. that was attributed to sepsis in 1928.

"Last year, in the United States, 18,000 women died of puerperal sepsis. Now, this does not begin to tell the true state of affairs. Only too frequently the cause of death is put down as pneumonia or other incident in the puerperal septic state, so as to avoid any possible question about errors in technique. If all those who had died of complications of puerperal sepsis were added to the above, and if to this figure were added all those who died of septic abortion, the number would, undoubtedly, be vastly higher".

J.R. Goodall, "Maternal Mortality."*CMAJ*, April, 1929, pp. 448-450.

[122] A similar situation seems to have existed all over Canada. For example, in 1932 in New Brunswick, the percentage of institutional births was 39.4. The maternal mortality rate was 5.1/1000 live births. When the figures were separated, they looked like this: institutional mortality, 9.3/1000; non-institutional mortality, 2.3/1000. The work of midwives and neighbour women, still practising very commonly at that time, would have been included in the latter figure.

A.F. McKenzie, M.D. "Notes on One Hundred Obstetrical Cases in Private Practice," *CMAJ*, Vol. 31, August, 1934.

[123] J.R. Goodall, McGill, "Maternal Mortality", *CMAJ*, 1929, pp.448-450.

[124] New York Academy of Medicine, *Maternal Mortality in New York City*, New York, The Commonwealth Fund, 1933.

[125] Richard W. Wertz, Dorothy C. Wertz, *Lying-In—A History of Childbirth in America*, *op. cit.*

[126] Iago Galdston, *Maternal Deaths—The Ways to Prevention*, The Commonwealth Fund, New York, 1937, p.51.

[127] Grant Fleming, M.D., "The Future of Maternal Welfare," *CMAJ*, Vol. 29, August, 1933.

[128] F.W. Jackson, M.D., R. D. De Fries, M.D., and A. H. Sellers, M.D., "A Five-Year Survey of Maternal Mortality in Manitoba, 1928-1932," *Canadian Public Health Journal*, Vol. 25, 3 March 1934, pp. 103-119.

F.W. Jackson, N.R. Rawson, E. Couture, "Maternal Mortality in Manitoba, 1933-1937 (second five-year period),"*Canadian Public Health Journal*, 1938.

J.T. Phair M.B., A.H. Sellers M.D., "Maternal Mortality in Ontario," *CMAJ*, Vol. 31, December, 1934, pp. 655-658.

Statistical methods were not up to the present level. For example, Phair and Sellers included this statement:

"We found that 61 per cent of the delivered cases were delivered in hospital and 39 per cent at home. In contrast to this, 73 per cent of the deaths occurred in hospital and 27 per cent at home; that is, 12 per cent of those dying were sent to hospital because of some complication or for being in extremis," Phair & Sellers, p.657.

[129] J.T. Phair, A.H. Sellers, *op. cit.*, p.576.

[130] H.E. Young and J.T. Phair, cited in Leslie Biggs, *The Response to Maternal Mortality*

in Ontario, 1920-1940, op. cit, p.124.

[131] Elizabeth Smellie, "Diet and Hygiene of Pregnancy from the Nurse's Standpoint," *Canadian Public Health Journal*, July, 1926, p.337. Read at Canadian Health Congress, Toronto, May 5, 1926.

[132] *Ibid.*

[133] Elizabeth Smellie, "Report on the VON." National Council of Women Annual Meeting, *National Council of Women Yearbook*, 1929, p.170.

[134] "Report on the VON," National Council of Women Annual Meeting, *National Council of Women Yearbook*, 1933.

By 1936, the Deputy Minister of Health for Canada noted that all three major nursing organizations—the VON, the Red Cross, and Assistance Maternelle of Montreal—had maternal death rates less than half the rate for Canada.

[135] Norma Philips Muir, *op. cit*, p.69.

[136] E.B. Pugsley, M.D., "The Canadian Welfare Council," *Canadian Home Journal*, 1941.

[137] J.T. Phair and A.H. Sellers, *op cit*.

[138] Canadian Medical Association, "Proceedings of the General Council" (in *Minutes of Canadian Medical Association Annual Meetings 1934)*, p.33. At: Canadian Medical Association Archives, Ottawa.

A similar report came from the Frontier Nursing service in Kentucky during this time. Their midwives reported that "the majority [of the clients] have parasitic infections.... Most of them show varying degrees of endemic thyroid disease and low-grade dental infections...16% of the women had secondary anaemia with haemoglobins of 8 mg or less...13% of the first 4000 women attended by the Frontier Nursing Service midwives exhibited symptoms of pre-eclampsia." In spite of the poverty of their clients, the midwives had a maternal mortality rate of .7/1000 births for their first 4000 deliveries attended (1925-40), compared to an overall U.S. rate of 6.2/1000 in 1933.

Robert W. Holmes M.D., "The Fads and Fancies of Obstetrics." *American Journal of Obstetrics and Gynecology*, 2: 1941, pp. 225-37.

[139] J.H. Duncan, "Neo-Natal Mortality (A Study of an Eleven-Year Period of Obstetrics in a Small City)", *CMAJ*, November, 1937, pp. 474-478.

[140] Ernest Couture, M.D., *The Canadian Mother and Child*, seventh printing, King's Printer, Ottawa, 1947.

[141] Public Archives of Canada, Maternal and Child Welfare Department, Vol. 992, File 499-3-7 Pt. 6, letter from Charlotte Whitton to Ernest Couture, October 5, 1940.

[142] Public Archives of Canada, Maternal and Child Welfare Department, Vol. 901, File 497-1-3, Roy Dafoe, M.D., *A Country Doctor Speaks to Women*.

In order to have the kind of absolute faith in one's doctor recommended by Dr. Dafoe, it was important to avoid social situations in which such faith might be undermined.

"Gatherings, such as bridges and teas, are often the occasions of unwise discussions as to the relative merits of doctors. After careful consideration, you have chosen a doctor, therefore do not let yourself be influenced by those whose judgement is no better than your own. There is nothing more disheartening than to hear your doctor criticized, or other doctors praised above him. To be happy you need to have complete confidence in your doctor. Anyone criticizing him to you (and at the same time knowing your condition) lacks discernment to say the least, and should not be taken seriously."

E. Couture, *The Canadian Mother and Child*, op. cit., 1940 edition.

[143] Ernest Couture, M.D., *The Canadian Mother and Child, op. cit.*, p.60. This and the 1940 edition had a distribution of more than two million in the years 1940-52.

[144] For example, in Newfoundland and Labrador, in the outpost areas, neighbour midwives (or "aunts" or "grannies") did not cease practising until sometime in the 1960s. See: Cecilia Benoit, "Midwives and Healers: The Newfoundland Experience," *Healthsharing*, Winter 1983.

Among native people of the North, babies continued to be delivered in the traditional way until the arrival of medical service nurses in the 1960s.

[145] A.H. Sellers, M.D. "Vital Statistics: The Recent Improvement in Maternal Mortality in Canada," Canadian Public Health Journal (31), 1940, 38ff.

Many observers, then and now, attributed the steep decline in maternal mortality to the advent of sulfonamides (then called Prontosil). This idea is disputed by A.J. Wrigley:

"Prontosil was certainly not available for general use before 1937, by which year the number of (maternal) deaths from sepsis had fallen from 800 (1934) to half that figure—347 [in Britain]. Penicillin, similarly, was not available in Great Britain before 1946, by which year the number of deaths from sepsis had dropped to a mere 53 per annum."

A.J. Wrigley, "Observations on Maternal Mortality," in R.J. Kellar, ed., *Modern Trends in Obstetrics*, Vol. 3, London, Butterworth, 1963.

In an article on puerperal sepsis in 1938, Dr. B.P. Watson, formerly of the University of Toronto but by then head of the Sloane Hospital in New York, admitted to his medical readers that he had as yet had no opportunity to use the new drug. "Let me say at the outset that I have no personal experience in [the use of sulfonamide] in puerperal infection, for it so happens that we have not had a single case of infection with a Group A beta haemolytic streptococcus since the drug came upon the market. We do not flatter ourselves that this is due entirely to the precautions we take against its entry into our patients; other factors probably play a large part, the most important of which may be the epidemological one.... It would appear that this is not a 'streptococcal year' in New York for I learn from my colleagues in other hospitals that their incidence of infections is also low."

B.P. Watson, M.D., "Puerperal Sepsis," *CMAJ*, February, 1938, pp. 139-42.

[146] A magazine review of a book, which asserted that modern medicine had caused an increase in life expectancy through its successful battle against infectious disease, prompted a forceful reply from Richard C. Lewontin, Professor of Population Sciences, Harvard University School of Public Health. He pointed out that not only tuberculosis but "nearly all the major killers of the nineteenth century" were "totally unaffected by the rise of modern medicine... [Nearly] all declined steadily with no observable effect of the discovery of causative agents, of immunization or of chemotherapy... The causes of the tremendous decline of mortality from infectious diseases in the last 100 years are not certain. All that is certain is that 'scientific medicine' played no significant part."

R.C. Lewontin, Letter to the editor, *New York Review of Books*, Vol. XXV, Number 21 and 22, January 25, 1979, p.47.

[147] Gladys Denys Shultz, "Cruelty in Maternity Wards," *Ladies' Home Journal*, May, 1958.

[148] Gladys Denys Shultz, "Cruelty in Maternity Wards," *Ladies' Home Journal*, December, 1958.

[149] Norah E. Cunningham, M.A., "Supportive Maternal and Child Care," *The Canadian Nurse*, Vol. 55, No. 11, November, 1959, pp. 988-995.

[150] Alice C. Mills, "The Role of the Nurse-Midwife in Great Britain," *The Canadian Nurse*, Vol. 55, No. 11, November, 1959, pp. 995-999.

[151] Charlotte Hanington, "Report on the Victorian Order of Nurses," *National Council of Women Yearbook, 1919-1920.*

[152] Kate S. Brightly, "Alberta Shows the Way," *The Canadian Nurse*, May, 1938, pp. 240-242.

[153] Dr. Otto Schaefer, interviewed in Toronto, 1986, *op. cit*.

[154] Rita Dozois, Medical Services Manitoba, interviewed in Winnipeg by Helen Ulickij, May, 1981.

[155] Jo Lutley, Medical Services, interviewed for this report, October 2, 1986.

[156] These programs ran until the late seventies. By that time many Medical Services nurses had taken the courses, and they closed for lack of demand.

[157] Dr. Otto Schaefer, *op. cit*.

[158] T.F. Baskett, "Obstetric Care in the Central Canadian Arctic." *British Medical Journal*, 1978, 2, pp. 1002-1004.

[159] T.F. Baskett, R.D. Bradford, and J.A. Hildes, Department of Obstetrics and Gynaecology and Northern Medical Unit, University of Manitoba, "Obstetrical Emergencies in the Canadian Arctic." Proceedings of the International Conference on Circumpolar Health, Nordic Council, Copenhagen, 1981.

[160] Mary Stevenson, Lecturer in Outpost Nursing, Dalhousie University, School of Nursing, Halifax, interviewed for this report, March, 1987.

[161] Additional informants about nurse-midwifery in the North were: Dr. John O'Neill, Assistant Professor of Medical Anthropology, National Health Research Scholar, Department of Social and Preventive Medicine, University of Manitoba; Dr. Brian Postl, Director of the Division of Community and Northern Medicine, University of Manitoba; Dr. Pierre Lessard, Obstetrician, Yellowknife, N.W.T.; Ms. Ruth May, Assistant Professor and Coordinator of Outpost and Community Health Nursing, Dalhousie University; Mrs. Hope Toumishey, Director of the Nurse-Midwifery Program, Memorial University School of Nursing, St. John's, Nfld.; Ms. Jean Slimon, Supervisor of Nursing Stations, Grenfell Regional Health Services, St. Anthony, Nfld; Ms. Peggy Ann Field, Director, Nurse-Midwifery Program, University of Alberta School of Nursing, Edmonton; Ms. Chris Robinson, nurse-midwife, St. Boniface Hospital, Winnipeg; Dr. Françoise Bouchard, Quebec City; Ms. Jenny Stonier, nurse-midwife, Povungnituk, P.Q.; and Dr. Gary Goldthorpe, formerly with Medical Services, Sioux Lookout.

[162] "Hiding from Harrassment," *The Globe and Mail*, November 10, 1986. Also: "Inuit Fight Loneliness for Safe Births," *Toronto Star*, March 23, 1987.

[163] *The Globe and Mail*, November 10, 1986.

[164] Jenny Stonier, nurse-midwife, Povungnituk, P.Q., interviewed for this report, March, 1987.

APPENDIX 2

Summary of Submissions Received by the Task Force on the Implementation of Midwifery in Ontario

Kate Hughes

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The Task Force on the Implementation of Midwifery received approximately 500 submissions from organizations and individuals. The following is a summary of the written submissions received by the Task Force and the oral presentations given at our hearings held across Ontario in October and November 1986. Since the hearings the Task Force has had further meetings with groups and individuals to discuss the issues in more detail and these discussions are not incorporated in the summary of submissions; similarly, many of the submissions received late could not be added into the summary.

1. HOSPITALS

Overview

In addition to a lengthy submission from the Ontario Hospital Association (OHA), the Task Force received 14 written submissions from individual hospitals across Ontario, several of which made additional oral representations at the hearings. These hospitals represent a good cross-section of Ontario hospitals as they range from small to large and cover all geographical areas of the province. As well, included in the OHA submission was a survey on midwifery conducted by OHA in preparation for its brief. Eighty-six Ontario hospitals responded to this survey which further ensured that the Task Force was well informed of the views of Ontario hospitals.

Both the OHA survey and the submissions received by the Task Force indicate that there is considerable support among Ontario hospitals for integrating midwifery into Ontario's health care system. Most hospitals concluded that midwives will play a positive role in developing family centred maternity care. There was a very small minority of hospitals that were opposed to the introduction of midwifery, at least at that particular hospital. There also was widespread concern by all the hospitals over issues such as insurance and payment of midwifery. The hospitals submitted that these were not insurmountable problems but felt that further studies and perhaps pilot projects were warranted to work them out. At least four hospitals were eager to participate in pilot projects in midwifery.

a) *Policy*

The OHA concluded that there is agreement among their members that midwives, practising in cooperation with physicians in hospitals, will play a positive role in the further development of a family centred approach to maternity care. This conclusion is in keeping with the submissions made directly to the Task Force by individual hospitals. One Toronto hospital stated to the Task Force that it believes that

> the implementation of midwifery, with its expanded holistic approach, would lead to an overall improvement in the health of both women and children and to improved obstetrical technique and overall quality of care within hospital settings.

Hospitals in other cities and towns, including those in the northern and southwestern parts of the province, were equally supportive of midwifery. The Chedoke-McMaster Hospital in Hamilton supported the implementation of midwifery and described its nurse-midwifery pilot project.

Only three hospitals made submissions to the Task Force which indicated they opposed midwifery at this time: The Listowel Memorial Hospital, The Tillsonburg District Memorial Hospital and St. Joseph's Hospital in Sarnia. The reasons for their lack of support varied; for instance, Tillsonburg District Memorial Hospital claimed there was no consumer demand for midwifery services. The Listowel Hospital felt that midwives were not needed, as public health nurses could perform the function of a midwife. The Sarnia Hospital submitted that, given increased funding, the needs of consumers could be met by making changes in hospital policies and environments without midwives. It stated:

> We would like to transform our stark delivery rooms and labour rooms into family-oriented birthing centres, but, funds are very limited for hospitals to provide proper facilities. Our facilities were built in 1944 and are extremely crowded and outdated.

Most hospitals do not share the view that problems in maternity may be resolved simply by making changes to hospital settings; however, the majority of hospitals agreed that these changes were needed as well as the introduction of midwifery in order to develop family centred maternity care and to meet the needs and wishes of consumers.

b) *Education and Entry to the Profession*

The OHA survey indicated most hospitals (97%) expressed a preference for midwives with a prerequisite of nursing education. Although a majority of its hospitals were strongly supportive of midwifery with nursing education, the OHA submitted that the issue of whether nursing should be a prerequisite for midwifery merits careful consideration especially as many European countries do not have this requirement. The OHA believes that hospitals are recommending midwives with a nursing background at least in part because they are more familiar with the skills of the nurse and the nursing profession.

A preference for midwifery with a nursing prerequisite was also found in the submissions of hospitals made directly to the Task Force, although it was clear that there was not unanimity on this issue. Of the submissions received by the Task Force, some hospitals recommended nurse midwifery, others simply assumed nurse midwifery, while others recommended nurse midwifery in the initial stages and still others expressed a willingness to work with midwives without nursing backgrounds. Those indicating a preference for nurse midwifery often expressed this preference because of the fact that there was a mechanism in place for licensing and discipline at the

College of Nurses. There was no discussion at the hospitals as to the pros and cons of the independent profession of midwifery but rather the main concern appeared to be the apparent administrative ease of implementing midwifery using an existing College.

At the oral hearings hospitals such as Scarborough Grace General Hospital and Women's College Hospital stated that their real concern was not whether the midwife was a nurse but whether she was qualified, competent and adequately prepared. They indicated that their interest in having midwives in the hospital would not be altered if midwifery without nursing training were implemented in Ontario.

Similarly hospitals expressed flexibility regarding the level and form of education of midwives as long as they were competently trained. Most indicated a preference for university level education although they also expressed a willingness to accept a midwifery program at the community college level. At least one hospital suggested that midwifery education should be both at the Undergraduate and Master's level. Women's College Hospital stated:

> The Master's level preparation may be particularly valuable for faculty of midwifery and research and the evaluation fields. The Undergraduate Degree program may produce the candidate most satisfied and skilled to provide the 'hands-on' primary care.

The OHA survey indicated that approximately one half of the hospitals preferred a university setting and only 14% favoured community colleges. The remaining hospitals recommended a combination of the two or an alternative setting such as an apprenticeship program with a midwife. These hospitals felt that "talent and commitment is more important than the setting".

The survey also indicated that the two main competency requirements suggested by hospitals were a minimum number of births in a year and continuing education. The minimum number of births recommended ranged from 5-100 per year.

Some hospitals submitted that birthing centres could be an excellent location for the training of midwives. For example, Women's College Hospital expressed a strong desire to set up the Women's College Hospital Alternative Birthing Centre:

> We envision a symbiotic relationship between the teaching of family practice residents and midwifery residents. We would envisage that the proposed 'Women's College Hospital Alternative Birthing Centre' would provide an excellent practicum for midwifery training. This initiative of the obstetrical group of the department of family practice proposes that both family practice residents and midwifery residents could be provided with a joint practical training setting at such a centre. Emphasis would be on team approach with responsibility divided equally amongst family practice and midwifery residents supervised by both midwifery and family practice of faculty members.

c) *Governance of the Profession*

The majority of individual hospitals recommended that midwives be regulated through the College of Nurses with the OHA survey indicating that 16% of its hospitals felt that midwifery should be self-regulating and 2% favouring regulation through the College of Physicians and Surgeons. The OHA itself stated that it had no formal position on the licensing of midwives or the establishment of a College of Midwives. It stated that this issue should be reviewed through pilot projects.

The submissions made directly to the Task Force indicated that, as with the issue of the nursing prerequisite, hospitals were flexible and were more concerned with competency requirements than with a specific form of regulation or education requirements.

d) *Scope and Standards of Practice*

The WHO definition of midwifery was acceptable to most of the hospitals, although approximately one third wish to modify the definition to have a nursing prerequisite or to limit practice to hospitals.

Generally, however, hospitals indicated that they thought midwives had a role outside the hospital and that there was more than one model of midwifery. OHA envisaged midwives working in a hospital based midwifery service, in group practice and in private practice. The type of service according to the OHA would depend on the preference of the midwives, the hospital and the needs of the community.

> OHA believes that there are at least three models within which a midwife may seek to practice. More than one model may be appropriate in Ontario depending on the size and type of hospital consumer demand for the service. Midwifery service may not be viable in all communities and hospitals and hospital boards must be free to make decisions on the feasibility of introducing midwifery practice and how the service should be provided.

One Ontario hospital indicated that if it were given discretion it would not introduce midwives into the hospital.

e) *Location of Birth*

Most hospitals felt that hospital was the most appropriate setting for birth; however, only a slight majority were opposed to home birth, according to the OHA survey. The OHA submission summarized the position of Ontario hospitals:

> Hospitals believe that a hospital, or a hospital birthing centre is the safest place for childbirth, because of the

> immediate availability of specialized medical care for both mother and baby in the event of an emergency. Hospitals recognize, however, that home birth with a midwife in attendance, would be the choice of some parents. OHA's survey of its members indicate that 45% of hospital respondents feel that there is a place for planned homebirth. Recent public opinion research commissioned by OHA indicates considerable support for alternatives to the hospital as a place of birth, including birthing clinics and home births.

Both the OHA submission and the submissions made to the Task Force by individual hospitals indicated that hospitals felt that if home births were to be a safe alternative better support systems for emergencies should be immediately available, including ambulances and flying ambulances for remote locations. A number of specific submissions were made in this regard.

Hospitals are more receptive to birthing centres than homebirths as an alternative to hospital birth. Although the majority of individual hospitals that made submissions directly to the Task Force did not address the issue of a birthing centre, three made specific recommendations that birthing centres be set up as alternatives to hospitals.

f) *Consumer Demand*

The majority of the submissions of hospitals and the Ontario Hospital Association submitted there was widespread consumer demand for midwifery and for "family centred" maternity care. With the possible exception of one, all hospitals expressed a willingness to make changes to their practices and policies to attempt to meet these demands:

> OHA believes that midwifery can play an important role in assisting to develop a family centred approach to care which meets the psychological needs of the expectant mother and father, and protects the health of mother and baby.

Most hospitals acknowledged that both changes to policies and practices in the hospital and implementation of midwifery were needed to provide optimum care. Although many hospital changes requested by consumers do not require large expenditures of money (such as changes in policies to allow fathers and midwives in the delivery room or to allow mothers and other family members to hold their newborn babies), many hospitals indicated that what was holding them back from making more changes was lack of funding.

Four Ontario hospitals told the Task Force that their hospital would be a good site for a midwifery pilot project (Port Arthur General Hospital, Women's College Hospital, Salvation Army Scarborough Grace General Hospital, and Doctors Hospital in Toronto). These hospitals indicated that preliminary discussions for pilot projects between hospitals and various educational and other institutions had taken place and that there was a "mutual interest".

The OHA recommended that before legislation is introduced a variety of pilot projects should be designed by hospitals in cooperation with the Ministry of Health. Temporary special authorization should be granted for the duration of the pilot projects to permit acts and practices of medicine to be delegated to midwives.

The various hospitals had different notions of what a pilot project would be. For example, Port Arthur General Hospital suggested that the hospital set up an outpatient clinic staffed by midwives and physicians that would provide prenatal education and counselling for clients as well as supplying midwives and physicians to attend during labour and birth. Doctors Hospital, which wishes to incorporate midwifery into its hospital and participate in the training of midwives, suggested setting up a complete birthing centre with private birthing rooms. It believes that due to the hospital's large immigrant clientele and the resulting high demand for midwives, it would be an ideal location for the introduction of midwifery.

g) *Economic Issues*

Hospitals indicated that insurance was a "serious concern" and major issue from their point of view. The effect of midwifery on insurance was unknown. OHA stated:

> If midwives are employed by hospitals, the hospital corporation will be liable for the actions of those employees. Professional malpractice insurance costs are rising significantly for family practitioners delivering babies, causing some to discontinue the service. What effect will the provision of midwifery service have on corporate liability insurance rates? Although OHA is unable to predict the effect with any accuracy, it seems reasonable to assume that liability premiums will increase.

If the midwife practiced with a physician or privately, hospitals indicated they would require the midwife to show evidence of liability insurance coverage and such coverage would be mandatory before the midwife could have access to the hospital.

Hospitals varied in their degree of concern over this issue. The majority simply stated that the issue was a concern and they wished further study. Others suggested that midwifery could be set up in such a way as to limit the risk of increased insurance (e.g., requiring midwives to have a certain level of training, etc.). Hospitals that were not in favour of midwifery submitted that it was possible that hospitals would not be able to obtain proper coverage if midwives were introduced into them.

Payment of midwives was another major economic issue for hospitals. The OHA survey indicated that 35% of the hospitals felt that midwifery should be an insured service under OHIP; 32% felt that midwives should be salaried employees paid by an employer which could include a physician, hospital or public health clinic; and 22% favoured a combination of OHIP and salary depending on where the midwife practised. A majority of the hospitals that submitted directly to the Task Force indicated willingness to have midwives in their hospital either as employees or as independent practitioners with admitting privileges. Some indicated a preference for midwives being salaried employees because then midwives could benefit from the umbrella of the hospital's insurance coverage.

The OHA submission stated that generally Ontario hospitals' operating budgets were severely limited at the present time and suggested that most hospitals would find it difficult to introduce hospital based midwifery unless the Ministry of Health provided additional funding. OHA believed that in the long run midwifery could prove to be cost effective. It stated that "the turn towards family centred maternity care, the use of midwives and less dependence on medical intervention could reduce costs in the long term".

The hospitals that indicated a desire to run a pilot project for the introduction of midwifery did not seem to feel that payment of midwifery was a large issue. They did note the desire that midwives be adequately reimbursed for their large time investment during pregnancy, labour and in the postnatal period.

Hospitals such as Doctors Hospital in Toronto felt that financing the introduction of midwifery should be made through the Ministry of Health capital grants to upgrade community hospitals. They argued that for the most part adequate birthing facilities have been funded by taxpayers and that these by and large have now fully depreciated. As these facilities obsolesce, they should be replaced by hospital-financed and -operated birthing centres. Hospitals could in turn be compensated for service provided on a case basis.

2. MEDICAL PROFESSION

Overview

The medical profession made its views known to the Task Force through submissions from the College of Physicians and Surgeons of Ontario, professional associations and groups and from a variety of individual physicians. Submissions from medical schools were also received but will be discussed under the section entitled "Educational Institutions".

There was divided support for midwifery with many associations and individuals taking an intermediate position of being supportive or at least tolerant but having a number of concerns especially as to how midwifery would affect the medical profession.

The views of medical groups, including the governing body and professional associations, will be discussed separately from the views of individual physicians.

I. Medical Colleges and Associations

The Task Force received oral and written submissions from the College of Physicians and Surgeons of Ontario, the College of Family Physicians of Canada, Ontario Chapter, the Society of Obstetricians and Gynaecologists of Canada, Ontario Chapter, the Ontario Medical Association (a separate written submission was received from the Obstretrics and Gynaecology section of the Ontario Medical Association), the Federation of Medical Women of Canada, and the Medical Reform Group. With the exception of the OMA, all expressed support or acceptance of the introduction of midwifery.

a) *Policy*

Most of these groups, such as the Society of Gynaecologists and Obstetricians, felt that midwives would be of "considerable benefit" to Canadian pregnant women and would contribute to the goal of the best possible reproductive care.

Reasons cited for the positive impact of midwifery by these various groups was that there was consumer demand, a desire by the medical profession to keep up with international standards, as well as the "widely recognized exodus of family physicians and obstetricians/gynecologists from provision of obstetrical care". The Medical Reform Group was fully supportive of the implementation of an independent self regulating profession of midwifery for a variety of reasons including the need in Canada for low technology birthing alternatives. The Ontario Medical Association was not supportive of the introduction of midwifery at this time as they felt that the medical profession can meet the evolving needs in maternity care and that a more active role for nurses will solve any present problems by the extended role nurse performing the functions of the midwife.

b) *Education and Entry to the Profession*

The College of Physicians and Surgeons, College of Family Physicians, the Society of Obstetricians and Gynaecologists of Canada (SOGC) submitted that uniform educational standards be implemented in Canada, preferably with training based on the standards in other jurisdictions. However, there was no consensus in the submissions on the specific content of the standards. The Medical Reform Group also recommended that training for midwives should be based on international standards. The OMA made no recommendations on the education of midwives. The Federation of Medical Women of Canada submitted only that "the standards of training should be rigorously controlled".

The submissions that addressed education were not committed to a prerequisite of nursing education. The Medical Reform Group came out the strongest arguing that nursing should not be an entry requirement and recommended that nurses who wish to train as midwives could be granted advanced standing for that portion of the curriculum which was already covered in their nursing training. The College of Family Physicians submitted that they saw "no significant problem with midwives going directly into training without a nursing background as long as the program provides adequate training". Similarly, the College of Physicians and Surgeons indicated that they had no preference for either nurse-midwifery or direct entry midwifery, although they required some formal training and would not support the introduction of what they called a "lay-midwife" without any formal education. At the hearings they added that there is sufficient evidence in the literature to allow them to make the choice between midwifery and nurse-midwifery and that "flexibility" should be established in the structure.

The SOGC, College of Family Physicians and College of Physicians and Surgeons all recommended that a minimum training period of approximately three years be instituted.

No strong preference was indicated for either university or college training, although it was suggested that the education be conjunctional with the Faculty of Nursing and Medicine with practice training in community hospitals.

Both the SOGC and the College of Family Physicians of Canada recommended that a minimum number of births should be established as part of the educational requirements or in order to maintain competence. Both of these Colleges also recommended that their organizations should play a role as part of a teaching team for midwifery.

The Medical Reform Group recommended that presently practising midwives should be offered certification if they undergo special course work and pass the appropriate examination under a "granny clause". It was submitted that this will prevent an underground practice of midwives which is not in the public's interest.

c) *Governance of the Profession*

Self-regulation was generally believed to be acceptable, although some of these groups believed that this decision should be delayed. For example, the College of Physicians and Surgeons recommended that initially midwives might be governed by an existing health care college and in the future if there was significant demand "there might be room for the development of an independent College of Midwifery".

The College of Physicians and Surgeons submitted that they were content with midwifery being either an independent, self-governing profession or a dependent profession that performs acts delegated by other professionals. They stated either was a "viable option" and the "choice between them depends on what role is determined that midwifery should play in the health care system".

The Medical Reform Group recommended strongly that a separate midwifery college should be established that is not subject to the supervision or regulation of any other health care college. Moreover, particular care should be taken to structure adequate public participation and accountability into the College of Midwifery and in this way it should depart from the established colleges.

OMA made no submissions on this issue.

d) *Scope and Standards of Practice*

Only the College of Family Physicians and the Medical Reform Group made direct submissions on the scope of midwifery practice. The College of Family Physicians defined the midwife as a "health care worker who is skilled in providing the necessary care, supervision and advice to women during pregnancy, labour, delivery, and the immediate post-partum period". They rejected the WHO definition and any other definition which extended the midwife's role into the field of gynaecology, family planning and child care.

In contrast, the Medical Reform Group was supportive of the implementation of the international definition of a midwife and was supportive of the view that the midwife could be a primary caregiver.

e) *Location of Birth*

Although most of these groups saw midwifery and home birth as being separate issues, all of the submissions addressed the issue of home birth and, with the exception of the Medical Reform Group, all of these groups were strongly opposed to the home birth option being available in Ontario. For example, the College of Physicians and Surgeons stated:

> The College maintains its position in regard to out-of-hospital births in that it believes that elective births in this environment should be discouraged. The College, therefore, does not support a midwifery program wherein the practice of elective home delivery by a midwife is encouraged.

The Federation of Medical Women of Canada submitted that it would like to see "midwives incorporated into the existing health care system, working in facilities equipped and staffed to deal with any obstetrical emergencies".

On the other hand, not only was the Medical Reform Group supportive of a woman's choice as to the location of birth but they were *not* supportive of hospital settings as an appropriate place for low risk birth. They stated:

> Existing hospital obstetrical units, disposed in terms of attitudes, staffing and equipment towards technological

> approaches and the management of obstetrical complications, frequently offer an inhospitable environment for uncomplicated low risk birthing. The likelihood of unnecessary amniotomy, anaesthesia, forceps delivery and episiotomy is substantial. Imperfect diagnostic procedures, such as electronic fetal monitoring, applied in low risk situations may result in significant numbers of normal labours being erroneously labelled as pathological. The rising rate of caesarean sections (currently about 20 per cent) may in part reflect this phenomena. (p.8)

As an alternative, the Medical Reform Group recommended that midwives and family physicians could provide their services in special low risk obstetrical units in hospitals, in free-standing clinics or in people's homes.

The Medical Reform Group cited extensive literature that they believed contradicted the view of that sector of the medical profession that opposed home birth. Although the Medical Reform Group acknowledged that there may be unforeseen complications which may arise, they submitted that this is not a rational reason for forcing women to give birth in the "far from ideal" setting of a hospital.

> While it is true that in a planned home birth complications may arise which could best be dealt with in a hospital setting, it is also true that hospital based technology may be used in an irrational and even dangerous manner and lead to complications which would not have arisen had that mother had a baby at home. The temptation to interfere with the normal by transforming it into the abnormal is too great for many hospital personnel and doctors to resist. Those of us who work in hospitals delivering babies have seen this phenomenon at close range.
>
> It is our view that neither the scientific literature nor the usual arguments regarding safety support the organized medical profession's opposition to planned home birth. We do not believe these physicians have the right to prohibit low-risk women from having home births if the women wish to do so. Therefore, we support the right of midwives and physicians to attend such births. Appropriate emergency support services should be developed to facilitate the safe management of unexpected complications. As a group of physicians we can state that there are doctors in Ontario who would be prepared to cooperate with legally recognized domiciliary midwives. (pp.14-15)

f) *Places of Practice*

These groups saw a number of models of midwifery as being acceptable. These include independent practice, collaboration with general practitioners or employment on a salaried basis by a hospital. The overriding concern was that midwives and doctors should work together as "a team".

All groups, with the exception of the OMA, indicated that a good working relationship between the physician and the midwife was essential. The Medical Reform Group discussed "models of linkage". They submitted:

> Since family physicians/general practitioners are the principal health care providers in the existing system, strong linkages between midwives and family physicians sharing care of patients must be developed. Two general models for this linkage can be identified:
>
> 1. Family physicians and midwives working together in community health centres or health service organizations.
> 2. Negotiated linkages between midwives and family physicians practising independently either individually or in formal or informal groups. (pp.15-16)

It was the view of the Medical Reform Group that the first of these models is preferable.

g) *Insurance, Payment of Midwives, and Other Economic Issues*

It was generally felt by these groups that litigation and the so-called "litigation crisis" was a major issue and that it would be essential that any licensed midwife be covered by adequate litigation insurance, tailored to the individual's type of practice. For example, the Federation of Medical Women of Canada submitted that "the legal responsibility and malpractice insurance provisions for midwives should be clearly defined".

The Medical Reform Group recommended that midwifery be "fully publicly funded". This should be in keeping with the principle that midwifery be reviewed as an alternative mode of primary obstetrical care rather than as a supplementary add-on to existing services.

The College of Family Physicians indicated that midwives should be paid under a model that recognizes their role, but that funding should also be available to family physicians with respect to any role they play in a birth managed by a midwife.

h) *Consumer Demand*

The submissions generally recognized public interest and consumer demand for the introduction of midwives. It was generally concluded that, as long as the current level of safety was maintained, care by midwives should be an option available to Canadian women.

The OMA departed from this view. Although they acknowledged that there was consumer demand, particularly demand by low risk women, rural women, ethnic women, native women and home birth advocates, they felt that alternatives such as midwifery should be limited as the interest of these women should be overridden by the "interests of the fetus". The Obstetrician and Gynaecology section of the OMA felt that consumer dissatisfaction was virtually a result of unrealistic expectations on the part of parents, often created by prenatal classes and books. They also submitted that the personality of patients and husbands played a role in consumer dissatisfaction. They submitted that as "safety is paramount" they were opposed to parents' rights, freestanding birthing clinics, home births, lay midwifery and midwifery as an independent profession.

II. Individual Medical Practitioners

The Task Force received 15 submissions from individual medical practitioners who range from obstetricians, general practitioners and family physicians to a paediatrician and a psychologist. Although these 15 submissions are not a good representative sampling of the views of all Ontario physicians, they are of interest especially if they depart in significant ways from the view of the regulating college and the professional associations.

a) *Policy*

The majority of these physicians were overwhelmingly in favour of midwifery. Of the 15, seven supported midwifery as an independent profession, three recommended some form of nurse midwifery and three indicated no preference as to the form of midwifery. Most of the physicians who were in favour of midwifery could be characterized as being strongly in favour of midwifery with the exception of three doctors who are not opposed to midwives, but who had concerns about the implementation of the midwifery profession dealing largely with fees and insurance and how midwives would impact financially on the medical profession.

These individual physicians articulated various reasons for supporting midwifery. Most indicated that they were convinced that the health care provided in Ontario would be greatly enhanced by midwifery and that they believed that there was a large demand for midwives by their patients. Many of these doctors indicated that family physicians and obstetricians in general as a group had a declining interest in the "normal birth" and had "little tolerance for the demands of the consumer".

Some physicians supported midwifery because they believed it provided something that they were unwilling or unable to provide. They reasoned that as there was demand for the family centred approach, the midwife could fill this need and thus was an "important adjunct for good health care in the field". For example, one family physician in Toronto who chose not to practise obstetrics believes her patients would benefit enormously from ongoing and family centred maternity care provided by midwives. A retired obstetrician went even farther and not only recommended the introduction of midwives but recommended that the general practitioner should be prevented from practising in the area as "very few had sufficient training in obstetrics or interest in current developments to make participation desirable".

Other doctors saw midwives as an alternative to the present system. The four doctors who indicated they worked with midwives were particularly supportive of the "unique" services of the midwife. For instance, two family physicians with large obstetrical practices related in detail their experience with midwives and both were highly supportive of the introduction of midwifery. Both of these doctors took pride in their "supportive, family centred, non-intrusive approach" and attributed this to the fact they worked with midwives. One doctor stated that midwives taught him much of what he knew about providing good supportive health care for women and that this had not been taught to him in his obstetrical training.

In general, these physicians saw midwifery as having many positive benefits for the public. As one doctor put it:

> Legalization of direct entry midwives and the creation of birthing centres would be two giant steps in the direction of an obstetrical utopia. We are convinced that perinatal mortality statistics would improve, patient satisfaction with birth experience would increase drastically, resulting in fewer lawsuits, and last but not least, in the long run, a great deal of taxpayers' money will be saved.

Only two doctors who made submissions to the Task Force were not supportive of midwifery, although they were not opposed in principle but appeared only to be against it at this time or in their particular community. One doctor made lengthy submissions regarding the lack of adequate literature supporting midwifery and home birth, however, in the end he opposed the implementation of midwifery because he did not believe there was sufficient consumer demand and the literature in favour of midwifery was limited. As a result, he submitted that the introduction of midwifery in Ontario was "premature" at this time.

The only other opposing submission was from a Dryden doctor who purported to represent the views of his medical community. This doctor was not opposed to midwifery in general, but was opposed to its implementation in his community. While this doctor recognized the movement of general practitioners and obstetricians away from normal birth in Ontario, he submitted that in Dryden there was "no vacuum for midwives to fill" and expressed strong concerns if midwives were introduced there would be little left for the Dryden physicians to do. Furthermore, in stark contrast with the submissions of consumers from Dryden and the surrounding areas, this medical physician submitted that the medical care given to women in the North was of the highest quality and that he "cannot see how midwives would provide better service than is already provided for obstetrical patients in Northwestern Ontario".

b) *Education and Entry to the Profession*

Several doctors made submissions on the issue of whether midwives should be trained as a prerequisite to entering the midwifery profession. Only three doctors either recommended or assumed midwifery would take the form of nurse-midwifery. The reasons for this recommendation varied. One doctor simply assumed that Ontario was implementing nurse-midwifery and felt that the midwives should be under the control of the medical profession. Another physician who recommended nurse-midwifery felt that although the midwives should have a separate College and be a separate profession, education and entry should be restricted to RNs. The last submission in favour of nurse-midwifery recommended only that midwives be selected from registered nurses at the present and that he believed that there was an interest among RNs in taking a more active role in birth.

The majority of submissions, however, recommended that midwifery be separated from nursing. One doctor who had the unique perspective of training and working as a nurse before becoming a doctor felt strongly about this subject. She asked:

> Should midwives be nurses? My experience as a nurse, before I became a doctor, forces me regretfully to say no. Professionalism in nursing is often synonymous with non-assertiveness, propriety, and a distressingly hands-off approach. Midwives who are nurses would be too accepting of the hierarchical way in which hospitals are run. Nurse-midwives working within nursing departments would not have the flexibility of independent professionals.

As for the content of midwifery education, the majority of submissions felt that midwives must be "well trained", although there was a scarcity of details as to what this meant. The consensus was that well trained meant that midwives should get some "formal education".

There was concern expressed that this formal education should not interfere with the education of family practice residents who would have to compete with midwives for exposure to deliveries. This was a concern of one of the doctors who was not supportive of midwifery. He stated:

> There may be indeed a place for midwife training, but it should not be at the expense of exposure for obstetrical and general practice residents at community and tertiary hospitals. If there is enough for both, then we have no objection. However, that remains to be seen and has to be carefully studied.

c) *Governance of the Profession*

The majority of submissions recommended that midwives would be more effective if they were an independent profession. Reasons given were that midwives are unique professionals separate from medicine and nursing and that they would not be able to perform this role if another profession were regulating them.

All the doctors who worked closely with midwives felt it was essential that midwives be independent. One doctor trained in Holland felt that nurses had little understanding of midwifery and saw midwifery as reminiscent of the "Dark Ages". He therefore recommended that midwives have no formal ties with the existing medical profession to ensure that the traditional midwifery approach, which has proved successful in other countries, would be the acceptable practice in an undiluted form in Canada.

d) *Scope and Standards of Practice*

There were few submissions from independent practitioners on this issue.

e) *Location of Birth*

Individual physicians were clearly divided on the home birth issue. Some were totally opposed to home birth under any circumstances while others attended at home births personally and indicated that they intended to continue to do so. Most of the doctors indicated concerns with home birth and with the lack of back-up systems presently in place in Ontario. For example, one doctor stated the following:

> I think of births that have occurred in hospitals with unexpected, potentially disastrous outcomes had it not been for the presence of a paediatrician, and I worry about home births. I then realize that my experience is at tertiary care hospitals which are lucky enough to have paediatricians physically present 24 hours a day. Most hospitals do not have these services and babies sometimes die needlessly. The fact is, some babies will always die — at home, at birthing centres and in hospitals. What we can do is minimize the risks by teaching midwives to recognize warning signs in pregnancy and labour. We can teach then neonatal resuscitation. We need good back-up for home births. We need to have a regulatory body, made up of midwives which can discipline midwives who ignore warning signs and keep women at home who shouldn't be there.

f) *Places of Practice*

The doctors in favour of midwives saw them practising in a wide variety of places, including independently and in group practice, in hospitals and in small birthing centres as employees, and in "teams" or "clinics" with physicians. One physician presently works with a midwife as a team and together they have managed 200 deliveries both at home and at hospital.

g) *Insurance, Payment and Other Economic Issues*

The main source of resistance to midwifery by medical practitioners who made submissions to the Task Force appears to stem from their worries about fees and insurance. Some of the submissions indicated that there was severe misunderstanding regarding the fees presently charged by midwives. One physician indicated that he believed that midwives were charging from $1,000-3,000 per birth, a figure well above that reported to the Task Force by midwives. Given the fact that he was limited as to what he could charge in fees by OHIP, this medical practitioner felt that the situation was unfair and that midwives should have their fees regulated in the same way that doctors do. Other doctors also had personal economic concerns as they felt that they could lose patients if midwives were allowed to practise.

A concern that was widespread among physicians was that of insurance coverage. The majority felt that as obstetrics is a high risk area it was imperative for midwives to have adequate malpractice insurance to protect the public. Several physicians expressed concerns that they should not be responsible for insurance coverage for the midwife and that the midwife should be forced to have her own independent coverage.

Other doctors cited the "skyrocketing" insurance fees as a reason for the need for midwives. They stated that obstetrical lawsuits as well as the recent ban on extra billing that has caused many doctors to quit doing obstetrics or to practise on a "rigid on-call system" have a great need for a new health care practitioner such as a midwife.

h) *Consumer Demand*

The physicians who were opposed to midwifery submitted that there was no consumer demand for midwifery. The majority, however, agreed there was great consumer demand for midwifery in Ontario and cited the following two reasons: increasingly knowledgeable and educated consumers who demand the unique qualities of a midwife as well as the withdrawal of obstetrical services by general practitioners.

Approximately one-half of the physicians acknowledged that there was this "gap" in services and that there were increasing problems in finding someone to attend at a normal birth. One doctor described the problem as follows:

> In ever increasing numbers, they [family physicians] are not getting involved in deliveries anymore. The reasons are complicated and they revolve around a desire for an enhanced lifestyle, lack of role models to extol the fun and rewards of obstetrics, fear of litigation and increasing malpractice rates when obstetrics is practiced.

Doctors were divided in their reaction to this shift in consumer demand; some indicated that it would make their practice easier to have access to midwives while others were concerned that allowing consumer access to midwives would hurt the practices and education of general practitioners.

3. THE NURSING PROFESSION

Overview

The Task Force heard many representations from the nursing profession through both oral and written submissions from the College of Nurses of Ontario, associations that represent nurses such as the Ontario Nurses Association, the Registered Nurses Association of Ontario and the Ontario Association of Registered Nursing Assistants, as well as submissions from individual practising nurses, nurse-midwives and nurse consumers. In addition, we received submissions from nursing schools and nurse administrators, although those submissions are included in discussions on educational institutions and hospitals and will not be repeated in this section.

The nursing profession, although supportive of the introduction of midwifery in Ontario, was divided on the issue of necessity of a nursing prerequisite for midwifery and the issue of whether midwifery should have a separate regulating body. The views of the College of Nurses, nursing associations and individual nurses will therefore be discussed separately.

I. The College of Nurses of Ontario

a) *Policy*

The College of Nurses of Ontario made both oral and written submissions to the Task Force. It was their submission that midwifery be recognized as a specialty of nursing under the College of Nurses. The College was of the view that some consumers were seeking out the services of midwives and that therefore the profession should be regulated to protect these consumers and the public at large.

b) *Education and Entry to the Profession*

The College of Nurses of Ontario was of the view that midwifery was a part of nursing and as a result submitted that nursing education should be a prerequisite to midwifery. At the hearings, the College of Nurses acknowledged that some of the nursing education would not be relevant to midwifery but stated that much of the program would be at least indirectly useful.

It was recommended by the College of Nurses that midwifery education be at the university level, in keeping with the general movement in nursing towards baccalaureate preparation as the basic requirement for nursing. It was submitted that in the initial stages, midwifery preparation should either be a certificate or a degree program within a degree-granting institution and built on basic nursing preparation. The long range goal of the College of Nurses was that midwifery preparation, as with other specialties within nursing, would be at the Master's level.

The College of Nurses submitted that entry into the profession by new midwives should be regulated by the credentialing process for specialization in nursing set up by the Canadian Nurses Association. In the alternative, it was suggested that the requirements for entry to the profession be:

1) current certificate of competence as an RN in Ontario and,
2) completion of an approved program at the university level and,
3) success on a written exam and,
4) payment of a fee.

The College of Nurses also had specific submissions on the issue of integrating currently practising midwives through a "grandmothering clause". A survey conducted by the College at the time of the 1986 registration renewal identified 5,053 registrants who appeared to have had midwifery preparation of some sort or another. In its written submission, the College urged that these individuals should be recognized for their preparation and experience and should be given opportunities to obtain additional preparation to meet the standards of safe practice. Thus, a "flexible" approach to entry to practice was recommended. A number of options were outlined by the College, along with the recommendation that whatever mechanism was established it was important to include both opportunities for individual assessment and appeal procedures.

The grandmothering clause would apply both to RNs with little formal training as midwives but who could demonstrate some level of competence at midwifery and to individuals who are currently practising in Ontario as midwives who are not RNs but had midwifery training in other jurisdictions that is considered satisfactory by the standing committee on midwifery set up by the College of Nurses.

c) *Governance of the Profession*

The College of Nurses submitted that it should regulate midwifery because it is a part of nursing. They submitted that this model is similar to that set up in the United Kingdom and those jurisdictions in the United States that have nurse-midwifery legislation.

Administrative clustering or regulation through a separate body was rejected by the College because it does not believe that midwifery is a separate health discipline; similarly, regulation by the College of Physicians and Surgeons of Ontario was rejected because "it fails to acknowledge midwifery is a specialty of nursing".

Cost was also cited as a major reason for regulation by the College of Nurses, although it stated at the hearings that it had done no studies in this regard. They felt that midwives would be too few in number to warrant a separate profession and rejected administrative clustering options. At the hearings, College representatives acknowledged that if cost were not a factor they would still be against the structuring of a separate profession of midwifery because it would add to what they perceived was the problem of "proliferation of professions".

d) *Scope and Standards of Practice*

The College of Nurses defines scope of midwifery as follows:

> Midwifery provides safe, family centred nursing care for well women and infants which is integrated into the health care system. The midwife is an independent practitioner who refers to, consults, and collaborates with members of various health disciplines, and practises in accordance with standards established by the College of Nurses of Ontario. The midwife:
>
> - manages care throughout the antepartum, intrapartum and postpartum periods
> - provides routine gynaecological care
> - provides family planning services
> - supports, advises, assists, and encourages the family to take an active role in their childbirth experience.

The College of Nurses felt that specific standards of practice will have to be established and in its submission lists acts that it believes should be included in the list of licensed acts for the practice of midwifery; these acts include ordering screening and diagnostic procedures, prescribing medication, assessing and monitoring, administering analgesia and co-conducting a spontaneous delivery.

e) *Location of Birth*

The College of Nurses does not support home births at the present time, but indicated a willingness to reconsider its position when midwifery is legally esatblished and support systems are available in Ontario. At the hearings it indicated that if the College were regulating midwives it would not discipline a midwife for attending a home birth if the midwife had fully informed the family about the risks of home birth.

f) *Places of Practice*

The College of Nurses made no submissions on this issue.

g) *Insurance, Payment and Other Economic Issues*

The College of Nurses made no submissions on the issue of insurance and payment of midwives.

h) *Consumer Demand*

The College of Nurses acknowledged that some consumers are dissatisfied with the present maternity care given by nurses and that these people wished an independent profession of midwifery. The CON felt that these problems could be addressed by solving the problems of overworking and understaffing in obstetrical departments in hospitals and perhaps by a separate professional association for midwives. Similarly, the CON acknowledged that there was some validity to the consumer criticism that nurses take an "illness oriented" approach but felt that this is currently being addressed by changes in nursing education over the last 10 years.

II. Professional Nursing Associations

a) *Policy*

The Task Force received submissions from the Ontario Nurses' Association (ONA), The Registered Nurses' Association of Ontario (RNAO), the Ontario Association of Registered Nursing Assistants (OARNA) and the Ottawa-Carleton Council of Nurse Executives (OCCNE). With the exception of the OARNA, these groups supported the view that midwifery was a specialty of nursing and that midwives should be trained in nursing and regulated by the CON. The OARNA however departed from the others and recommended mixed or direct entry education for midwives and an independent profession with a separate regulating College.

b) *Education and Entry to the Profession*

The ONA and the RNAO both submitted that midwifery is a specialty of nursing and that the minimum requirement of entry into the practice of midwifery should be a basic registered nursing education with advanced preparation in midwifery. Direct or mixed entry to midwifery was not supported by these groups.

RNAO was of the view that the midwifery program should be at the university level for the following reasons:

> Placement of midwifery education in a university environment would be consistent with educational requirements for other professionals who provide primary health care. Nursing specialty practice requires advanced knowledge and skills and midwives may ultimately require a Master's degree. In addition, collaboration with other accredited educational facilities to provide components of the program would increase accessibility and allow utilization of current resources.

The Ottawa-Carleton Council of Nurse Executives were also of the view that midwifery education should be at the university but stated that it should be immediately at a postgraduate level with the majority of OCCNE members supporting the requirement of a Master's degree.

ONA and RNAO were supportive of some sort of grandmothering or advanced standing provision for currently practising midwives, especially the nurses who identified themselves in the CON survey as having midwifery education.

These groups recommended that midwives trained elsewhere should be provided with an opportunity to meet educational requirements through a variety of programs including challenge exams, refresher programs, part-time studies and other options.

The Ontario Associaton of Registered Nursing Assistants fundamentally differed in its views from the other associations, disagreeing that midwifery is an expansion of nursing. It supported mixed entry to the profession because of their belief that the nursing prerequisite would deny many individuals the opportunity of entering the profession without completing a three-year diploma nursing program. OARNA stated:

> We believe a direct entry, community college program to be a more economical approach and would leave the door open for all to the profession. A few excellent examples of direct entry programs established by the Ministry of Health are the Emergency Medical Care Attendant, the Paramedic and the Chiropodist. All have a distinct knowledge base and function very well within their defined roles.

c) *Governance of the Profession*

ONA, RNAO and OCCNE all recommended that midwifery be governed by the College of Nurses because of their basic premise that midwifery is a specialty of nursing and because they believe that it will be less costly, although they acknowledge that regulation by the nursing profession is not the norm in other countries. The RNAO submission states:

> Regulation, certification and/or licensing of midwives is controlled in many countries by a separate college of midwives. The cost of self-regulation is high and is borne by the practitioner, while the cost of educational preparation is borne by society as a whole. At present, educational programs which could be adapted to educate midwives are in place. The College of Nurses can fulfill the role of regulator of the practice and protector of the public.

The OARNA on the other hand is opposed to regulation of the profession by CON, even if it were found to be more economical. It states:

> Although clustering may be feasible for economical and administrative purposes, for a few of the smaller membership professions it is imperative that each retain their autonomy. We, as RNAs, have experienced the undemocratic clustering with Registered Nurses under the present College of Nurses of Ontario structure. To even consider clustering RNs, RNAs and Midwives under one College of Nursing would be disastrous to the profession of midwifery. With 35,000 RNAs, for instance, we have but a token representation of eight RNAs out of a 33 member decision-making CNO Council. With the much smaller number of Midwives, their proportional representation would be negligible. They would very quickly lose their recognition as a distinct profession or have any impact on decisions surrounding their scope of practice.

OARNA recommended setting up a separate College of Midwifery to regulate midwives and to be responsive and responsible to the public. It submitted:

> OARNA believes this College of Midwifery should be responsible for developing and revising the standards of midwifery practice, inspection of the midwifery educational programs to ensure they are maintaining the standards of the profession, defining and revising the scope of practice of the midwifery profession and through the consultation process, negotiating areas of overlap with other professionals.

d) *Scope and Standards of Practice*

The Ontario Association of Registered Nursing Assistants accepted the World Health Organization definition of the midwife and recommended that it be adopted in Ontario.

RNAO defined the midwifery scope of practice as to provide care to low risk women during normal pregnancy, labour, birth and puerperium and to the normal newborn. The midwife also has a supportive role for the woman who is experiencing a high risk pregnancy.

ONA saw midwives as essentially having the same scope of practice as a nurse practising in a community health setting involved in health counselling and education, family planning and child care and as the hospital nurse working on labour, delivery and postpartum floors. In addition to basic nursing activities, nurses in hospitals might perform the following added skills and sanctioned medical acts: foetal monitoring, monitoring of individuals receiving uterine stimulating drugs, rectal examination of the cervix, performance of vaginal examination during labour, performance of a medio-lateral episiotomy when the likelihood of perineal tear is apparent. In addition, ONA submitted that any proposed scope of practice must recognize that it overlaps with those activities performed by nurses.

e) *Location of Birth*

OARNA and OCCNE made no submissions on the home birth issue.

ONA stated that it recognized the consumer demand for home birth as well as the "client's right to choice of services" and admitted that its proposal of midwifery would not meet the needs of these clients because it desired to limit midwifery to specialized nurses acting within the institutions. ONA stated its belief

> ...that it is best when birth occurs in a setting where appropriate equipment and personnel are available in the event of obstetrical emergencies. Deliveries would therefore take place within a hospital or similar facility, i.e., birthing centre. However, we also recognize the desire by some clients for planned home births. Such clients might be forced to utilize the services of unqualified personnel if we limit the role of nurse midwives to institutional settings.

RNAO also recommended restricted location of practice while at the same time acknowledging consumer demand for home birth. It believes that a movement to family centred practices and policies in hospitals would reduce the consumer demand and desire for home birth. It stated:

> Midwifery is not synonymous with home birth; they are separate issues. RNAO supports midwifery but does not support planned home birth. While the midwife is often the birth attendant of choice for low-risk women, it is preferable that birth occur in a hospital or facility equipped to handle obstetrical emergencies. Midwives must be given the opportunity and privilege to work in such settings. Hospitals are developing, albeit slowly, more flexible family centered policies, implementation of which can reduce the consumer's interest in and desire for planned home birth. Changing hospital attitudes and the community based early discharge programs offer a framework in which midwives can meet the physiological and psychological needs of families. (p.4)

f) *Places of Practice*

ONA and RNAO saw midwives as practising only in hospitals and community settings (in association with established medical practices or by public health agencies). They did not endorse independent practice. Similarly, OCCNE recommended:

> Nurse-midwives should be salaried employees in a health care facility with a flexible role, permitting them to be directly involved in both the birthing process in hospitals as well as a community role in the antenatal period.

g) *Insurance, Payment and Other Economic Issues*

Of the professional groups only RNAO addressed the issue of insurance for midwives. It stated:

> The current climate for liability insurance makes it imperative that midwives be covered by professional liability insurance. Such coverage may be provided by an employer but independent insurance or additional insurance coverage beyond employer coverage may be desirable for midwives. At present, both RNAO and ONA have professional liability insurance for their members. While we will attempt to continue to provide such protection for all members the uncertain future of liability insurance in the province may present insurmountable difficulties. (p.5)

RNAO submitted that payment for midwifery services should be the responsibility of the provincial government and stated:

> A mechanism should be developed whereby health care facilities, community agencies or established medical practices wishing to utilize midwives can receive gov-

ernment funding for midwifery care. Salaries should reflect midwives' advanced preparation, expertise and accountability.

ONA addressed the issue of collective bargaining rights for midwives. If midwives were employees then they would be covered by the Ontario Labour Relations Act. As it is a certified trade union representing registered and graduate nurses, ONA submitted that if midwifery were a specialty of nursing and if midwives were employed in health care facilties where ONA held bargaining rights, then midwives would be members of the ONA's bargaining unit and subject to the pay schedule negotiated in the collective agreement. If non-nursing midwives were allowed to practise, ONA might admit them to membership if they were a two-thirds majority vote at an ONA general meeting to allow midwives in their union.

If midwives were independent practitioners they could still engage in collective bargaining, not under the Ontario Labour Relations Act, but in the same form as the Ontario Medical Association engages in collective bargaining with the Ontario government to establish OHIP fee payments.

ONA submitted that all nurses, and presumably midwives if they were nurses, should receive the same rate of pay regardless of employment setting with additional pay based on advanced educational preparation. It further submitted that pay equity should be considered and negotiated for midwives to "eliminate the historic and systematic underevaluation of women's contributions to the workforce".

h) *Consumer Demand*

As discussed, these groups acknowledged the public demand for midwifery and for home birth. In particular OARNA explicitly stated that it supports "the government in recognizing the need for introducing midwifery practice, as it is a viable alternative for families who seek less traditional approaches to the birthing experience".

III. *Individual Nurses*

We received approximately 65 submissions from individual nurses who wished to voice their opinions directly to the Task Force separately from the associations that represent them. These submissions represented a good geographical cross-section of Ontario as they came from all areas of the province. The submissions from nurses could be divided roughly into three categories: submissions from nurses speaking from the perspective of consumers, submissions from nurses who identified themselves as "nurse-midwives" and submissions from practising registered nurses and registered nursing assistants. We have attempted to distinguish between these three categories of nurses when summarizing the decisions of nurses on various issues.

a) *Policy*

Unlike the College of Nurses, and the professional and union associations representing nurses, the overwhelming majority of the individual nurses who made submissions to the Task Force were strongly supportive of the introduction of midwifery as a self-regulating profession independent from nursing.

There were over 20 submissions of nurses who personally chose to use midwives ("nurse-consumers") and were particularly supportive of an independent profession in midwifery. These submissions as well as the submission from the Toronto Nurse-Consumer Group (representing 15 nurses) described themselves as representing the "educated-consumer approach".

These nurse-consumers articulated a variety of reasons for hiring midwives. As for many of the other consumers, some of these nurses chose midwives because they had negative experiences at the birth of their first child in hospitals with doctors. One RNA from the Kitchener-Waterloo area expressed dissatisfaction when her first child was born in a "regular hospital delvery complete with bright lights and a room full of masks!" These nurses all articulated much more positive experiences with midwives. Other nurse-consumers stated that as members of the medical profession they were aware of the problems and attitudes of the medical profession ("if technology was there, we might as well use it" attitude).

Other reasons were also cited for choosing midwives. The nurse-consumers wanted the continuity of care, the unlimited time and lack of paternalism that midwives offered. A Chatham nurse chose midwifery because she wanted home birth and could not arrange medical back-up for this decision. An Oshawa nurse decided on midwifery because she wanted to have a vaginal birth after a caesarean and could not find a doctor who would aid her in this regard.

The nurse-midwife submissions offered another perspective. This category does not cover all midwives with nursing training who made submissions, but only those who described themselves as "nurse-midwives". These women were familiar with both the nursing and midwifery professions. Most of these nurse-midwives had experience in other jurisdictions and were able to give insight from that perspective. The majority of them felt strongly that midwives need not be trained as nurses and recommended that midwifery be a separate profession from nursing.

We also received just under 40 submissions from practising nurses across Ontario who wished to relate their personal experiences in the maternity care area and their thoughts on the implementation of midwifery. All of these nurses, with the exception of one nurse who identified herself as being an administrator of a hospital, were supportive of midwifery as an independent profession. The majority of these nurses recommended multiple routes of entry into the profession and did not believe that training in nursing was necessary for midwifery.

b) *Education and Entry to the Profession*

Individual nurses departed markedly from the nursing associations and groups and from the College of Nurses by recommending that a full nursing education was not only unnecessary but also would be detrimental to midwifery training. All three categories of nurses recommended multiple or mixed routes of entry to the profession, without a nursing prerequisite.

All of the nurses who identified themselves as "nurse-consumers" rejected nursing training as a necessary prerequisite. One nurse stated her reasons for this:

> Despite recent initiatives, nursing as a profession is lagging far behind in terms of developing a practice which is responsive to the needs of health consumers. Serving the needs of a medical profession and the directives of the employing hospital takes up much of the nursing functions. Nursing education ("training") has tended to produce individuals who are geared to work and assist in work which is task-oriented and subservient — not the kind of individual who, as a midwife, can and must make independent judgements if evoked to meet the health needs of the childbearing family.

Many nurses recognize that there is some overlap in nursing and midwifery but stated it was not enough to make it the same profession. As one Oshawa nurse stated:

> It would be a shame if the profession became nurse-midwifery. As a registered nurse, I know the majority of my training did not apply to maternity care. What purpose would it have been to train a midwife to deal with cancer, orthopedics, cardiology, etc. It would not only be a time waster and an added expense for the midwife but it also lowers the number of RNs graduating that would be available to work in the hospital and other medical settings. The nurse/midwife would also be medically trained before continuing to use unnecessary medical interventions for normal and low risk women.

The majority of nurses who identified themselves as "nurse-midwives" felt strongly that midwives need not be trained as nurses, and as a result of their nursing training they came to the realization that nursing is geared to illness and problem oriented. They felt that not only was much of nursing education unhelpful for midwifery but that "the illness orientation" made it necessary for one to "unlearn" certain nursing biases. In particular, many nurse-midwives submitted there were problems because the midwife is a primary caregiver and has a different relationship with physicians and other staff than does the nurse. Moving to an independent role is not an easy progression for the nurse to make.

The only nurse-midwife who recommended a nursing prerequisite was trained in England where the nurse-midwife is a norm. She is presently practising in Northern Ontario and notes that there is a general scarcity of health practitioners. Her rationale for supporting nurse-midwifery is that it would enable the nurse-midwife to care for the whole patient and recognize other medical problems if they arise.

The majority of nurses believe that university education is necessary in order to gain respect from other professions, but that the program should be specific to midwifery. A minority were in favor of advanced education at a Master's level.

One nurse, however, had concerns that the university level of education is not appropriate for midwifery. She argues that midwifery is "an art not a science" and therefore certainly a graduate degree would not be appropriate to educate midwives except to train them to become teachers or supervisors. Moreover, she stated the university entrance to nursing is a North American phenomenon and is not the international standard. If midwifery were at a graduate level then the education would be too similar to that already in place for a doctor and the length of time involved would be similar to the length of time required to get a medical degree. As a result, the cost both for students and to the public at large would be high while the financial rewards for the midwife would in no way rival that of the general practitioner with a similar education.

Most nurses also felt that the apprenticeship model of training used in other countries for midwives is a good idea for Ontario. The emphasis according to the nurses' submissions should be on both theory and practice.

The nurses who made submissions on the grandmothering issue were in favour of currently practising lay midwives being integrated by certification or retraining, depending on their various levels of preparation. Many of the nurse-midwives have worked with lay midwives and found them in their opinion to be equipped to meet the needs of the birthing family. All the "nurse consumers" were in favour of currently practising midwives being allowed to continue to practise, whether or not they had formal training.

c) *Governance of the Profession*

The vast majority of nurses were supportive of midwifery as an autonomous profession.

The individual nurses were well aware that their views were not in accordance with the College of Nurses and nursing associations. As one London public health nurse who recently gave birth with the assistance of a midwife stated:

> I know I have departed the College of Nurses with my views, but please be reminded that I speak as a converted skeptic. It is my experience that has brought this

conversion about.

The only exception was the nurse-midwife from Northern Ontario who preferred nursing training for midwives; she submitted that as the College of Nurses was already in place it would be easier for the College of Nurses to regulate the profession rather than setting up a separate College.

The remaining nurses generally disagreed. One of them stated that midwives should not be denied an independent profession simply because there were not sufficient numbers of qualified midwives at this time to support a separate College. She recommended that until there were qualified personnel to fill positions at the College of Midwifery administrative clustering could be implemented. Many nurses felt that midwifery should have its own College and set its own standards as no profession should be charged with governing another profession.

d) *Scope and Standards of Practice*

Generally the nurses recommended the WHO definition of midwives. It was recognized that there was overlap between midwifery and other professions such as nursing. Nurses felt that it was common for professions to overlap and as with other professions these overlaps can be worked out. There was particular concern with the overlap between midwifery and public health nursing. Two public health nurses, who were supportive of midwifery, recommended that a dialogue be established between public health nurses and midwives to delineate clearly the separate scope of midwifery practice.

e) *Location of Birth*

Nurses as a whole did not see the home birth and the midwifery issue as being tied up together. They did however acknowledge a movement by consumers towards home births. While many personally did not feel that home births were safe at this time without more adequate back-up, most felt that it was a matter to be left to the individual woman. Many nurses recommended that a compromise between home birth and hospital birth be implemented, such as birthing centres.

The majority of nurse-midwives were in favour of the home birth option for parents. They stated they felt compelled to help parents who wanted this alternative and wished that their training was both in hospital and home birth in order that they could better meet the needs of consumers. One nurse-midwife was not in favour of home birth and felt that her unwillingness to accept home birth came from her hospital-based training.

Many of the nurse-consumers had themselves chosen home birth. As with the nurse-midwives, they tend to be very supportive of the home birth choice as well as birthing centres or birthing homes (separate from the hospital building) staffed by midwives.

f) *Places of Practice*

As discussed, although some nurses were not personally in favour of home birth most of the nurses recommended that midwives be able to practise in hospitals, in clinics and birthing centres and in clients' homes.

g) *Insurance, Payment and Other Economic Issues*

Nurses and nurse-midwives in particular were concerned about issues like insurance. They recommended that midwifery be structured in such a way that Ontario midwives do not have the problems of American midwives in getting insurance companies to insure them.

The nurses were in favour of midwives being paid either through OHIP or as salaried employees.

The nurses were generally of the view that midwifery would be cost effective. The nurses working in hospitals indicated that midwifery could help by cutting down hospital costs through the earlier discharge of patients and through the management of real and false labour, postpartum care and counselling.

h) *Consumer Demand*

The individual nurses who made submissions to the Task Force indicated that there is a strong need for midwifery. Particularly the nurses who worked in maternity care in the hospital settings indicated that the needs of the consumers were not being met by any other medical practitioner. For instance, one nurse indicated that many women arrive in hospital in false labour or too early in labour and that this would not occur if the woman were under the care of a midwife. This early arrival has dire consequences as the nurse believes that the induction of labour usually ensues rather than sending the woman home.

These nurses were overwhelmingly concerned about the lack of continuity of care. Hospital nurses stated that there is no way that a woman could get any semblance of continuity of care in a hospital in that several nurses, residents, interns, medical and nursing students are usually involved in her care. Nurse consumers indicated that the lack of continuity of care was one of the main reasons why they sought out the services of a midwife. One nurse consumer stated that she wanted someone to stay with her throughout the whole labour and that she knew that

> [t]his does not happen with hospital staff. It is not part of their job to stay with an expectant mother through her whole labour. They are too busy with too many people to look after. Shift changes, different nurses come and go. Different doctors, residents, interns, etc. 'drop-in', and 'leave again'. It is disrupting and bothersome.

As well, nurses stated that the growing trend in hospitals of early discharge unfortunately results in parents often feeling cut-off and without access to counselling about newborns and postpartum care, breastfeeding and parenting.

Nurses who were trained outside of Canada often felt frustrated working in maternity care in this country. Several expressed dissatisfaction with the fact that many doctors did not show up at the delivery or showed at the last second and the full responsibility for the delivery was placed on the nurses although they were very much limited in what they were allowed to do in their practice. One nurse described the following:

> When the patient was progressing well on second stage my time was spent preparing for the doctor's arrival and dashing to the patient to check foetal heart, maternal pulse and blood pressure instead of giving my whole attention to the needs of the patient at this vital stage of labour.
>
> The delivery room was set up like an operating room with an operating table for delivery, very uncomfortable, cruel really for the patient. There were monstrous stirrups for legs to fit into which were very difficult to adjust. The patient was in entirely the wrong position for normal delivery, like having a bowel movement while lying flat on one's back.
>
> Episiotomy or tear was unavoidable in most cases because of the position of the thighs, thrown into opposite directions ... the obstetricians were good but some of the general practitioners were not so good; it would have been better to refer the patient to the obstetrician. It is hard for a general practitioner to be good at everything; by definition they are not specialists.

This nurse recommended that there would be better care for the consumer if the midwife were a specialist in normal birth.

Many nurses were concerned about the over-medicalization of birth. As one nurse put it:

> Perhaps the greatest advantage midwifery has to offer is the humanizing influence. Pregnancy is not a disease but a normal physiological process. The implementation of midwifery could help reverse trends towards increasing medicalization of childbirth and unnecessary technical interventions in an otherwise normal process.

4. MIDWIVES

Overview

The Task Force received approximately 30 submissions from midwifery associations and individual midwives. The midwives discussed in this section do not include the women who describe themselves as "nurse-midwives", as they are already discussed in the nursing profession section. This distinction is admittedly arbitrary, as many of the midwives who did not describe themselves as nurse-midwives also had some nursing training.

This section does not discuss the various chapters of the Midwifery Task Force, a group of consumers supportive of midwifery, as it will be discussed with other consumer groups. The groups discussed here are limited to those representing midwives, such as the Midwives Alliance of North America, the Midwives Association of Canada, the Association of Ontario Midwives, the Midwives Association of British Columbia, the Alberta Association of Midwives, the Association of Midwives of Eastern Ontario, the Midwives Collective of Toronto and the Midwifery Student Group.

As there was much agreement between the position of the group and the individual midwives, all of these submissions will be discussed together with different viewpoints noted as necessary. Generally the submissions were all expressly supportive of the very detailed submission of the Association of Ontario Midwives. As its submission has been discussed in detail throughout this report, the focus in this section will mainly be on the views of individual midwives.

a) *Policy*

The midwives view birth as a normal process. Although they state they are committed to a scientific evaluation of obstetrical and midwifery practices, they reject much of the medical model of maternity care and the unjudicious use of technology. They submit that the midwifery model is based on a holistic approach of care which includes an emphasis on continuity of care, informed choice, educational counselling and the appropriate use of technology. The midwifery model incorporates both a different philosophy and different practices from those of the medical and nursing profession.

b) *Education and Entry to the Profession*

The Association of Ontario Midwives recommends that the education of midwives be at the university level leading to a Bachelor of Science in Midwifery. This would be a four year degree completed in three calendar years with an emphasis on clinical experience. Entrance to this program would be "mixed entry" or "direct entry" and there would be no nursing prerequisites. Currently practising midwives would be "grandmothered", as discussed elsewhere.

Individual midwives were in agreement that midwifery should be mixed entry as there was consensus that midwifery differed fundamentally from nursing. Even the midwives who had nursing backgrounds rejected a nursing prerequisite. One midwife who had a nursing background (although she did not identify herself as a nurse-midwife but simply a 'midwife') stated:

> While I value all of my higher level education, I feel it would be a mistake to require all midwives to be nurses. I've learned these professions separately and view them

> as having distinct goals, philosophies and methods. We have a unique opportunity in Ontario to create a 'new' health profession in a model that is fresh and ideal while still being practical. It would be a step backwards for midwifery to have to take on all the inherent problems that the nursing profession presently faces by becoming a part of nursing.

Most of the midwives acknowledged that parts of nursing education are valuable to a midwife and should be a component of the program but they said that the program should not require a midwife to take a whole nursing degree or diploma. For example, a midwife with a nursing background submitted: "in my experience, ...little basic nursing skills ... involved in midwifery care ... these few would be better taught within the larger context of a complete midwifery education".

At least some of the midwives felt that in the North, nurse-midwifery might be appropriate because of the unique problems of the North. As stated by one midwife:

> In most communities, as a midwife could not make a living with only a few births, the nurse-midwife could be an appropriate health care professional. Nurse-midwives in outpost stations would be able to conduct deliveries under normal circumstances and only send out those which need the attention of an obstetrician. Most of the time, however, they would be working as a nurse. This would not only result in happier women but it would also save the government a considerable amount of dollars.

Many Ontario midwives were concerned that a large portion of midwifery education, whether at the university or community college level, should be focussed on hands-on practice. The majority favoured an apprenticeship aspect of the education as nothing could replace the "one-on-one learning situation of sitting through clinical visits watching a midwife practise examination skills, counselling skills and attending births in the position of the observer and then assisting the supervising practitioner".

Most of the practising midwives were educated in one way or another including midwifery education in England, The Netherlands, Scotland, Germany, Guatemala, United States, Africa and New Zealand. Others were educated "informally" by apprenticeship training and the taking of courses taught by other midwives. Many had some nursing training or university or community college education in a related field. There was a feeling among the "informally" trained midwives that their education was "piecemeal".Although they felt fortunate that they were able to get apprenticeship training, and considered their personal education to be adequate, they thought that it took considerable effort on their part to create this educational package.

Midwifery students also made submissions to the Task Force as to the present system of midwifery education. They indicated that there were apprenticeship positions available but only for a lucky few students and that most were forced to do "self study", correspondence courses and to work as "labour coaches". The labour coach training was inadequate as most labour coach work was restricted to hospitals. They therefore had little exposure to midwives who tended not to practise in the hospitals.

Many midwives also had concerns about midwifery schools being accessible both in terms of geography and finances. They recommended part time courses including some correspondence courses and preceptorships to make the program more open to women with children.

Individual women were also concerned that previous experience be considered by midwifery schools in order to give some women advanced standing in the program. This would avoid the midwifery education from being too repetitious for women with nursing or other related experience.

A further concern was the perceived need for a large component of clinical training and exposure to other midwives. Many midwives felt that it was essential that midwifery be taught largely by midwives rather than by academics or members of other professions. Currently practising midwives felt that many of their practices and policies had been handed down by other midwives and that no other profession could adequately teach these aspects of midwifery.

There was also a concern that lengthy formal education would not change the attitudes of hospitals and other professions. One midwife, for instance, indicated a willingness to reattend at a university to get the stipulated education for midwives but she did not believe this would have much effect on her local hospital or the attending obstetricians. She believes that university education alone would not be enough to give credibility and acceptance in the health care community.

Understandably, the practising midwives were concerned about a "granny clause". Almost all of the midwives indicated that currently practising midwives must be integrated into the system without having to do a full midwifery course. As one midwife put it:

> The currently practising midwives have responded to the demands and needs of people and have relearned the art of supporting natural childbirth and confidence in women's ability to give birth. Years of preparation have gone into this and the 30-35 midwives now working in Ontario possess experience, skills, knowledge and intuition that cannot be mass produced in midwifery education and institutions.
>
> It is for this reason that these women be allowed to continue to practise under a "granny clause" in legislation for to lose what we have learned and have to offer

> would be a retrogressive step of the worst kind. Perhaps these women could be best used in individual centres of the province to offer learning experience for aspiring midwives and training. It is the only way to preserve what we now have and know. While most of us will be very willing to be examined individually and to meet certain criteria to assure equal standards of competence and skill, it must be remembered that we have spent years offering prenatal care, managing on our own childbirths in and out of hospital settings, and providing care and counselling, and we have a very high level of satisfaction among the families we serve.

Most other midwives also explicitly indicated they were content with the phase-in proposal of the Association of Ontario Midwives. They stated that they would personally be prepared to upgrade their education in substantial ways as well as accept proposals for ongoing refresher programs for midwives.

c) *Governance of the Profession*

The Association of Ontario Midwives recommended that midwifery be structured as a self regulating profession based on the "midwifery model" with a gradual phase-in of the self-regulation to ensure safe standardized practice. This self-regulation would be phased in by establishing a provisional governing body.

All of the individual midwives indicated that they wanted to be governed by an independent College of Midwifery which would set the standards and scope of practice. Many midwives who had worked in other countries indicated that without self-regulation midwives were not able to give high quality care as they became controlled by another profession.

Midwives were in agreement that their standards of practice should include informed consent contracts, risk screening criteria, peer review, and a midwifery code of ethics.

d) *Scope and Standards of Practice*

Midwifery associations and individual midwives all endorsed the international definition of midwives as established by the World Health Association. In addition, most midwives indicated they saw midwives as being specialists in normal births as well as having a role in high risk birth.

e) *Location of Birth*

The midwives associations were supportive of families having a genuine option to choose the place of birth and they stress "informed choice". They believe home birth could be made safer with proper back-up for midwives and the support of the medical profession.

Individual midwives indicated that they set up their practices to be responsive to consumer demands and that they respected parents' rights to make educated decisions regarding the location of their birth, as long as parents meet the requirements of a medical examination to assess risk.

Some midwives indicated a preference for home births because of the present policies restricting their role in hospitals. None of the midwives was against home births and all were in agreement that consumer desire for this form of birth is not going to disappear. As one midwife put it:

> It should be remembered that if one ignores the needs of families who will choose to birth at home, and no matter what has been available in other settings those needs will not disappear, these needs will be met by midwives (or inexperienced persons, or no attendants at all) who will work under great pressure and fear of persecution.

One midwife estimated that 40% of her clients chose home birth for a variety of reasons including a wish to be in one's own environment, hygienic reasons, a need for "respect" which they believe is unavailable in hospitals, a wish for family involvement and bonding and a fear of unnecessary medical interference.

A majority of the submissions specifically noted that the midwives had a good relationship with ambulance attendants, although such services could be improved. One midwife stated:

> We do, of course, need protocols for midwives, ambulance attendants and hospital emergency staff for dealing with transports from home deliveries — protocols that define roles and ensure continuity of care. My experience is that we have a good foundation that promises to build an excellent back-up system for home birth in both rural and urban Ontario and that Ontario is ready for a broad-based program of domiciliary midwifery.

Some of the midwives of the North indicated that home birth is a special problem in remote areas because the practice in these locations is to fly women out of the community six weeks before the birth date. Many women try to avoid the transport by lying about their birth date, thus endangering the safety of themselves and their babies. This problem would be avoided by implementing midwifery and home birth services which allow women to stay in their community in the case of normal birth.

f) *Places of Practice*

Midwives indicated a desire to be able to practise in hospital, birth centres and in homes according to consumer wishes. Most midwives indicated they would not endorse the model of midwifery that structured rotating shifts of midwives in a hospital.

Midwives indicated a desire to be allowed to practice independently, in group practices with midwives or other health care professionals, or as employees in health centres and hospitals, although the majority indicated a strong preference for group midwifery practice.

Midwives also indicated that there is a different style of practice needed for rural and urban midwifery. For example, they feel that consumers in rural areas tend to have fewer options due to the unresponsiveness of rural and small city hospitals ("one hospital towns"). Consumer impact is limited in these locations and change is slow. Thus independent midwifery practice is especially needed in these areas.

g) *Insurance, Payment and Other Economic Issues*

Midwifery associations recommended that midwives be provided with access to insurance and that insurance premiums should reflect that midwives deal with low risk births; they should not be at the same level as premiums for obstetricians who are specialists in high risk births. The midwives tend to believe, based on the international situation, that malpractice is not a large problem for midwives, especially if they stress "informed choice contracts" to minimize malpractice problems.

The Midwifery Association of Canada supports universal coverage for midwife services under provincial health insurance schemes in order to ensure that midwifery services are available to all women regardless of their economic status. Provincial insurance coverage should include prenatal, intrapartum and postpartum care, counselling services and neonatal and contraceptive care.

Many individual midwives stated that at present they were not being well paid for their services given the number of hours they devoted to their work (one midwife estimated she was paid 50-75¢ per hour because she spent an average of 70 hours with each client).

h) *Consumer Demand*

Midwives believe that there is a very high consumer demand for their services. At least one-half of the submissions from individual midwives indicated that they entered the profession because of consumer demand. The following submission from one midwife is typical:

> During the past 10 years, a growing number of parents have been frantically searching for alternatives in birth, some to the extent of birthing alone without a skilled attendant. For this reason I feel compelled to help them.

Consumer demand is particularly acute among immigrant women. One Spanish-speaking midwife indicated in her submission that her Spanish-speaking clients were, due to cultural reasons, especially interested in being attended by female midwives and in home birth rather than in hospital birth.

Midwives seem to feel that consumers were seeking out their services for the following reasons:

1. They researched the midwifery option and decided that they wished the unique services of a midwife;
2. They were discontented with hospital experiences (for example, their first children were born in hospital and these birth experiences were traumatic or unsatisfactory);
3. They desired home birth or alternatives such as vaginal birth after caesarean and could not get their physicians to assist.

The midwives indicated that their clients came from a variety of backgrounds, and tended to be well educated rather than from a "lunatic fringe" as portrayed by the medical profession. One midwife described her clients as follows:

> They are generally well-informed individuals who want alternatives and choices in their birth experience. They desire an active involvement in the process, and believe that birth can be a normal healthy event. At the same time they wish to do all that they can to ensure good conditions for mother and child. Generally, they speak of the need for education, guidance, support and ongoing continuous care from someone they feel they know, in a personal and trusting manner, and they do not feel this is currently provided in our maternity care system.

5. EDUCATIONAL INSTITUTIONS

Overview

A number of educational institutions, both at the university and community college levels, made submissions to the Task Force and attended meetings with the Task Force to discuss their recommendations and the implementation of midwifery education in Ontario. As well, the Task Force received submissions from the Council of Ontario Faculties of Medicine (COFM) and the Ontario Region, Canadian Association of University Schools of Nursing (ORCAUSN). Educational institutions were accepting of the implementation of midwifery in Ontario, and many expressly indicated that they felt that the implementation of midwifery was a positive step. Many also indicated a willingness to participate in setting up and carrying on educational programs for midwives.

I. Council of Ontario Faculties of Medicine, and Ontario Region, Canadian Association of University Schools of Nursing

a) *University or CAAT?*

The Council of Ontario Faculties of Medicine submitted that the midwifery education program should be established only at the university level because of "the obvious need to recognize the high level of professional responsibility required of midwives" and to encourage "close collaboration with other health professionals who are university trained". The ORCAUSN was in agreement that midwives should be trained at the university level in keeping with the current movement in nursing.

b) *Nursing Prerequisite?*

Both COFM and ORCAUSN submitted that a B.Sc. in Nursing should be a prerequisite for entry into midwifery. ORCAUSN recommended that the title of nurse-midwifery would be used in Ontario as midwifery "is a branch of nursing just as obstetrics is a branch of medicine".

c) *Undergraduate or Graduate Level?*

The COFM submitted that midwifery programs be at the Master's Degree level following the B.Sc. in order that "the best people would be attracted to the program" and to enhance credibility with the public and other health professionals. Similarly, ORCAUSN recommended that the nursing schools offer the midwifery program at the Master's level of education.

d) *Curriculum*

COFM submitted that it was premature to give detailed recommendations on midwifery course content; however, in their opinion "the curriculum should involve didactic and clinical components with exposure to the basic sciences (anatomy, physiology, pharmacology), behavioural sciences and clinical sciences". Clinical experience could be obtained at birthing centres or hospitals. Due to the shortage of clinical exposure for medical students, it considered that it may be necessary to expand the number of hospital units that currently exist in the university hospital systems.

ORCAUSN recommended that family centred maternity care should be a major emphasis in the "curriculum because it strengthens the family bond, improves standards of behaviour and increases the happiness of individuals". They also recommended that more than one institution (hospital or community agency) be affiliated with the university to accommodate large components of clinical teaching in the program.

II. Universities

The Task Force received submissions from the University of Toronto, the University of Western Ontario, the University of Windsor, the University of Ottawa, Queen's University and Lakehead University as well as Ryerson Polytechnical Institute. A number of universities made more than one submission; the UWO Department of Family Medicine made a submission separate from the Department of Obstetrics and Gynaecology, and the Queen's School of Nursing made a separate submission from the Department of Obstetrics and Gynaecology. As well, the University of Toronto made two submissions — one on behalf of the Department of Obstetrics and Gynaecology and the other on behalf of the "Obstetrical Interest Group of the Family Practice Department, University of Toronto" (representing approximately 40 family physician teachers).

a) *University or CAAT?*

All of the universities submitted that midwifery should be at the university level and not at all at the community college level. The Queen's Department of Obstetrics and Gynaecology argued that the university program is preferable as it has well developed internal and external mechanisms of review and accreditation to ensure quality of the process. As well, universities are centers of development of "new knowledge" and professors are ideally suited to keep their teaching programs at the forefront of biomedical knowledge. Several universities, including the schools of nursing at the universities, indicate a desire to participate in the training of midwives if their recommendations about the program are accepted.

The Department of Obstetrics and Gynaecology at the University of Toronto indicated a desire to be involved with the training of midwives but cautioned that it does not wish this training to be at the expense of current undergraduate and postgraduate programs for medical students. Competition for patients is high at the present time. The Faculty was open to considering associations with new hospitals not currently affiliated with the University of Toronto.

Submissions from the faculty members of the Family Practice Department at the University of Toronto also indicated a strong desire to become involved in the current movement to incorporate midwifery into the health care system; they stated that maternity care in this province would change significantly in the future. These faculty members indicated that many of their members had worked directly with midwives and they felt that this experience was of particular value in formulating guidelines of practice. They stated that the interaction had been positive with only occasional problems due to the poorly defined status of midwives.

b) *Nursing Prerequisite?*

With the exception of the University of Toronto Department of Obstetrics and Gynaecology, all the universities recommended the implementation of some form of "nurse-midwifery", with a nursing degree being the prerequisite to entry into the midwifery educational program. Many of the submissions did not address the issue of how midwifery differed from nursing although some submissions, such as the submission from the Queen's University School of Nursing argued that putting midwifery in the nursing stream would provide more opportunities for nurses to advance and to specialize. It was noted that currently within the nursing profession there is little opportunity for development.

The University of Toronto submission made on behalf of their Family Physician teachers indicated that they were not committed to nurse-midwifery. The latter submission recommended that midwifery be recognized as an independent practice without direct supervision by anther profession including the medical profession. Although they thought that previous nursing training might be one way of entering midwifery this should not be the exclusive way.

c) *Undergraduate or Graduate Level?*

Although not all submissions addressed this issue, most recommended that midwifery be at the graduate level. For example, University of Windsor envisaged midwifery as being at least one year beyond a nursing degree and that it should eventually be at the Master's level. They felt that such a Master's program should have a large research component.

d) *Curriculum*

The universities envisaged midwifery training as having a large overlap with obstetrical training for medical students. For example, the University of Western Ontario Department of Obstetrics and Gynaecology felt that the basis of education for midwives should be the core curriculum for undergraduates in medicine. Their rationale is that only by basing midwifery education on these educational objectives and the associated evaluation programs will midwifery be acceptable to society and to its medical peers.

The University of Toronto family physicians felt that midwifery should not have such a large overlap with medicine; they saw the profession as being independent even to the extent of recommending a separate College of Midwifery to regulate the profession. They saw midwives as having strong links with the medical profession especially as midwives use medical consultation when appropriate, but that this would not necessitate such a large degree of overlap in the educational process. They did see midwifery students and medical students working together in their clinical components in birthing centres and in hospitals.

e) *Other Comments*

A number of universities had additional submissions to make on midwifery in addition to the educational issue. For example, the Queens School of Nursing made submissions regarding the payment of midwives. They recommended that the issue of adequate payment for midwives be addressed. They submitted that the midwifery profession

> must deal with issues such as expected working hours, fair payment for service, benefits and third party payment (i.e., OHIP). In addition it must take into account the principle of equal pay for work of equal value. Undereducation, underpayment and overwork have categorized women's work ghetto too long!

The obstetrical interest groups of the Family Practice Department of University of Toronto had submissions on models of practice of midwifery. They submitted

> that the midwives provide care on the basis of best possible continuity of care, i.e., their pre, intra, and postpartum care is provided by the same person or group of midwives. We do not support the model of shared-care where the actual delivery is carried out by a separate hospital-based group of midwives who do not provide pre and postnatal care. This would remove one of the most important features of good primary care obstetrics — high continuity.

III. Colleges

Six Ontario Community Colleges made submissions to the Task Force indicating tht they would be interested in establishing a midwifery program at their institution (Loyalist College, Seneca College, St. Lawrence College, Mohawk College, Algonquin College and Humber College).

Most of these colleges indicated that they thought that midwifery education should be implemented at the university and college level. It was their view that the college level provided a more flexible educational system that was willing to set up part-time educational programs as well as refresher and continuing education courses.

Most of the Community Colleges envisaged midwifery as a subsection of nursing. They felt that their faculty would consist of midwives, obstetricians, general practitioners and nurses certified with additional obstetrical skills. Humber College, however, recommended that midwifery should be set up as a separate profession. They submitted that if midwifery were assigned to any of the distinct governing bodies it would influence the role of the midwife. Initially, "The College of Midwives" should have representation from a number of health care bodies including midwives, family physicians, obstetricians and nurses.

Humber College saw multiple routes of entry to the profession but did not recommend "direct entry". They did not believe, however, that nursing training was a prerequisite, only that the midwife have an appropriate health sciences background such as nursing, medicine, midwifery education elsewhere or training as an ambulance paramedic.

6. HEALTH COUNCILS AND DEPARTMENTS OF HEALTH

Overview

Task Force contacted all 26 district health councils in Ontario to invite submissions reflecting the councils' assessments of area health needs and priorities as they might bear on midwifery. In particular, we requested any available epidemiological information regarding infant/maternal mortality and morbidity, as well as the councils' perceptions of local interest in or receptiveness to midwifery by consumer and health professionals.

Nine health councils across Ontario responded, supplying various degrees of information on health statistics and submissions on midwifery. Several health councils conducted surveys and health meetings to obtain input from health care professionals and consumers in the area. Although not all of these submissions contained recommendations or could claim to have done exhaustive surveys, for the most part the submissions indicated that the health councils were supportive of midwifery. In particular the health councils indicated that there was a need and a growing interest in midwifery, particularly in northern and rural areas of Ontario where the health councils reported problems of women being unable to obtain good maternity care. They also articulated concerns for high standards, good midwifery education, accessibility in rural areas and the need for locally trained midwives.

A summary of the health councils' submissions follows.

1. Cochrane District Health Council

In preparation for their submission, the Cochrane District Health Council had a number of informal discussions with service providers and consumers from the district and reviewed the infant/maternal morbidity data for the area.

The epidemiological information supplied by the health council indicated that the total perinatal mortality rate for the northeast area of the province was higher than for the province as a whole. These statistics caused the Health Council concern. The Health Council was also concerned about the number of women in isolated areas who are relocated in order to give birth, although there were no statistics compiled on this.

The Health Council's informal discussions indicated there was both a need and a desire for midwifery in their district. For instance, the Council stated that two doctors in their district are "very pro-midwife". The administration in a hospital in the district also indicated that midwives are desired by patients. The head nurse at the James Bay General Hospital reported that up until 10 or 15 years ago all deliveries north of Moosonee were attended by midwives but that this had changed and that most expectant mothers must come down to Moose Factory in order to give birth. She believes that the Northern area would benefit greatly from the implementation of midwives.

The Health Council believes that the lack of continuity of care is a particular problem in the James Bay area, where physicians work in short term locums of a minimum two weeks to three months. A woman in this region could typically receive care from as many as eight different doctors during the course of her pregnancy. The Council also has concerns about the care given to native people in the area. Language barriers, lack of accommodation, cultural differences, and geographical isolation all create problems. The Council urged the Task Force to consider northern health needs and priorities in the implementation of midwifery.

2. Grey-Bruce District Health Council

The Grey-Bruce District Health Council is supportive of midwifery. As the area is largely rural, consumers in the area often have to travel long distances to doctors' offices and hospitals. There are many consumers who want the services of midwives but as there are no members of the Association of Ontario Midwives practising in the area the consumers are presently travelling to Kitchener, Waterloo, Hamilton, Guelph or Toronto for midwifery services. The Health Council is concerned that midwifery should be reasonably accessible both geographically and financially to all Grey-Bruce citizens.

The Council is content with the midwife practising as an employee of the hospital, independently or with any other agency. However, informal or formal affiliation with the hospital is important for continuity of care according to the Council.

The Council notes concern for increasing health costs and recommends that midwifery should be cost effective. Pilot projects should be encouraged and the District Health Council should be considered for one of the pilot projects.

3. Manitoulin-Sudbury District Health Council

The Manitoulin-Sudbury District Health Council submitted that midwifery could form an important addition to perinatal services, particularly in outlying communities. Statistics indicated that perinatal mortality and morbidity rates in the area are exceptionally high compared to the rest of the province. They attribute this to a number of factors, including reduced accessibility of perinatal services, different prenatal practices of mothers, and socio-economic conditions.

Midwifery was viewed as a positive addition to health care. In the larger regional centres midwifery could provide a complement to offer women a greater choice. In the smaller outlying communities midwives could potentially increase accessibility to perinatal and postnatal care. The Health Council, however, raised concerns about possible "turf" battles with doctors and hospital staff.

The Health Council believes that midwives should be included in OHIP to maximize accessibility. It is in favour of midwives being able to work in small group practices.

It felt that midwives are uneconomical at the hospital level because of the budget of the hospital.

It strongly recommended that at least one school of midwifery be located in the North. It felt that problems with midwives could be overcome by public and professional education concerning midwifery.

4. Middlesex-London District Health Unit

In a very brief submission the council supported midwifery because of the underlying principle that consumers should have a choice in the delivery of health care. It is in favour of the midwifery model that has a nursing prerequisite and raised some concerns about the overlap of public health nurses and midwives.

5. *Rainy River District Health Council*

The Rainy River District Health Council conducted a very limited survey (10 individuals) to obtain their opinions regarding midwifery services. The majority of these individuals were physicians who saw very little need for or interest in midwifery in the area. However, they were supportive of midwifery in part, in that they were in favour of native and other midwives to meet the very real need of postpartum health care in the area. All of the remaining individuals they surveyed, namely midwives, consumers, and public health nurses, stated that there is a great interest in midwifery care in the area.

The Health Council statistics indicated that the Kenora Rainy River District has a much higher infant mortality rate than the Ontario rate (just over 100% higher) and that the birth rate in the area is also 35% higher than the provincial rate. The majority of the hospital deliveries in the district occurred in hospitals that delivered fewer than 300 babies per year and there is only one certified obstetrician in the district. As a result a large majority of deliveries is handled by general practitioners.

6. *Rideau Valley District Health Council*

The Rideau Valley District Health Council held a meeting to discuss the implementation of midwifery. At the meeting the WHO definition of a midwife was adopted. The Health Council also concluded that it did not believe that nurse-midwifery was necessary but that a specific training program for midwives should be established which included training on both physiological and social topics.

The Health Council indicated that it noted a decline of general practitioners practising obstetrics in the area, particularly in the rural communities. The availability of trained midwives might help solve this problem. The Council felt the problems regarding the integration of midwives into the current system are primarily hospital based, but can be overcome by hospitals revising policies and procedures (and in some cases the physical layout of the facilities) in order to provide the appropriate environment to assist the delivery.

In the rural areas the Council felt that "travelling midwives" would be an asset.

The Thunder Bay District Health Coalition, a non-profit public interest group, indicated that there was a great need in northwestern Ontario for midwifery. Many isolated communities are without physicians and even in Thunder Bay there is a lack of choice of services. The Coalition supports the position of the Association of Ontario Midwives. The Coalition felt that the educational requirements set out by the Association of Ontario Midwives should be the "supreme limit of education" needed to provide well-trained competent midwives. They felt that practice experience was essential and that an entire year should be an intensive hands-on internship. Training programs were recommended at Lakehead University to try to solve the problem of northwestern Ontario's inability to attract health care providers.

The Coalition stressed that the call for midwifery is a result of the public's criticism of the present system as being impersonal and fragmented. Thus the Coalition felt that it was important for midwives to be "practical people-oriented" and for midwifery to be implemented in such a way that midwives are not just second class medics.

7. *Waterloo Region District Health Council*

The Waterloo Region District Health Council was supportive of the implementation of midwifery. It stated that in some of their rural areas, such as the ones resided in by Old Order Mennonite women, midwives could be particularly helpful.

Health statistics in this area indicated that perinatal and mortality and morbidity rates were satisfactory but that there was a much higher birth rate than across the province. At present there are three obstetrical services and three acute care hospitals as well as a birthing centre, the St. Jacobs Family Birthing Home, which at present is limited to providing prenatal education and nutrition classes.

The Health Council did not feel that midwives had to be nurse-midwives but felt that the training of the midwives should surpass that of a registered nurse in the area of maternity care. They were concerned that there be a uniform education preparation for all midwives.

The Council wished to restrict its comments at this time to midwifery in a hospital setting as it did not wish to comment on the home birth issue.

8. *Peel District Health Council*

The Peel District Health Council recommended the introduction of midwifery in Ontario and submitted that both consumers and providers in their area are receptive to the introduction of midwifery.

Peel District has 43 labour delivery beds, 15 obstetricians and one midwife as well as a number of family physicians. In 1979 the District Health Council commissioned a study in midwifery care and a consumer survey; the results indicated that nearly one quarter of area women would choose the services of a midwife.

The Peel District Health Council accepted the WHO definition of midwifery, with the exception of the extension of the role into gynaecology and child care. They recommended that midwifery be established as a specialty of nursing under the scope of the College of Nurses.

9. *Department of Health, City of Toronto*

The Task Force also received a submission from the Department of Health, City of Toronto which expressed a keen interest in setting up a pilot project. The Department has had discussions with various hospitals and is suggesting a joint project with another hospital, community centre or group practice of physicians. It indicated that it could employ three or four midwives in the four health areas in the City of Toronto. As there are more than 8,000 births a year in the City of Toronto, the Department feels that it would have more than enough work for three or four midwives (it employs 250 nurses). The target groups for midwifery services would be immigrant women and teenage women.

The Department submitted that they are interested in a pilot project involving formally prepared nurse-midwives but will also consider the utilization of other midwives who are legally recognized pursuant to recommendations of this Task Force. The Department recommended "formal preparation" for midwives but did not restrict itself to nursing education.

The Department recommended that midwives be salaried and that the midwifery services be funded by the Ontario Government as an approved health care activity.

In summary the Department submitted that the recent health care trends and literature support change in the introduction of midwives as "an efficient and effective alternative".

7. ORGANIZATIONS

Overview

Task Force received approximately 60 submissions from a wide variety of public interest organizations, in addition to the submissions from groups representing doctors, nurses, midwives, hospitals and health councils which have all been discussed previously. We have categorized these diverse groups as follows:

I. Consumer Groups (not including individual consumer submissions)

II. Women's Groups

III. Childbirth Groups

IV. Non-health Professions

V. Other Organizations

I. Consumer Groups

The Task Force received submissions from the following consumers' groups: Consumers' Association of Canada (Ontario), Association of Concerned Citizens for Preventative Medicine, Thunder Bay and District Health Coalition, Concerned Citizens of Chelmsford, Ontario, and submissions from nine Ontario chapters of the Midwifery Task Force (an organization of parents who have used the services of midwives).

a) *Policy*

Generally, all these groups were supportive of an independent profession of midwifery, and all took the position that the birth experience should be the choice of the informed mother. Most of these groups expressly supported the submission of the Association of Ontario Midwives, and some also indicated that they supported the submission of the Medical Reform Group.

The submissions of the Midwifery Task Force Chapters were particularly supportive of midwifery and many of the submissions related to detailed personal experiences to illustrate their positive experiences with currently practising midwives in Ontario.

Chapters of the Midwifery Task Force from areas outside Toronto (such as Sudbury, Kenora, Oshawa and midwestern Ontario) where there are few hospitals that handle obstetrics indicate an even greater need for the services of midwives; these "one hospital" areas in their view are particularly slow to respond to the request of consumers, and thus the choices and options of women giving birth are extremely limited.

b) *Education and Entry to the Profession*

To ensure the safety of the public these groups were concerned that there be adequate training and maintenance of high standards for the midwifery profession. None of these groups saw nursing as a necessary prerequisite. Chapters of the Midwifery Task Force believe that if nurse midwifery were introduced there would still be consumer demand for non-nurse midwives in Ontario.

It was recommended by the Midwifery Task Force that a four year program in midwifery at the university level should be implemented but there must be a mechanism for allowing presently practising midwives to be integrated into the system. Midwifery Task Force members indicated a high level of satisfaction with these midwives and indicated they wished to continue to use their services.

c) *Governance of the Profession*

The consumers' groups were in favour of midwifery being an independent self-regulating profession in keeping with the

Association of Ontario Midwives' recommendations.

d) *Scope and Standards of Practice*

The various consumers' groups all felt that midwives should be unsupervised primary caregivers practising according to international standards.

e) *Location of Birth*

Consumers' groups were very much in favour of informed choice, including choice over the location of birth. The Midwifery Task Force Chapters indicated that one of the main reasons why their members originally choose midwives was in order to have this choice over birth setting.

f) *Places of Practice*

Most consumer groups sent no submissions on this issue beyond endorsing the AOM submission. It was clear from their submissions that they envisoned midwives working both in hospitals and outside of hospitals.

g) *Insurance, Payment and Other Economic Issues*

The consumer groups had no submissions on this issue beyond endorsing the AOM submission.

II. Women's Groups

The Task Force received 24 submissions from Canadian women's groups representing a broad range of perspectives. The spectrum ranged from the Ontario Coalition for Abortion Clinics and other feminist groups to R.E.A.L. Women of Canada. These groups represented a wide range of women, including immigrant women, women of the north, the women's health movement, students, women in law, homemakers, women from specific political parties and women from both the urban and rural areas. Although these groups ranged widely in perspectives, philosophies and politics all of these submissions were supportive of the implementation of midwifery in Ontario.

a) *Policy*

The majority of women's groups saw the introduction of midwifery as necessary in order to give women choice over their reproductive life. For instance, the Toronto Women's Health Network characterized midwifery as a women's issue. They stated:

> Central to our ability to have control over our bodies and lives is the ability to make choices on issues such as birth control, sexuality, sexual orientation, pregnancy and childbirth. In the same way that we advocate universally available safe and effective birth control, including the option of abortion, we support a woman's right to give birth with the professional of her choice, in the setting of her choice, in the manner of her choice.

A common theme among women's groups is also the dissatisfaction with the present health care system. For instance groups such as Women Working with Immigrant Women (WWIM) submitted that the present health care system does not meet the needs of women from different cultures who are accustomed to midwives and do not feel comfortable with male physicians at hospitals. The present health care system is viewed as not acting in women's interests while midwifery is seen as women-oriented. As the Ontario Coalition for Abortion Clinics stated:

> As part of the women's health movement, we know how important the contemporary re-emergence of midwifery has been. It arose out of a profound dissatisfaction of countless women with the dehumanized, authoritarian and misogynistic nature of hospital based obstetrical care. Women were searching for alternatives to the dominant medical model which saw birth as a pathological and dangerous event requiring vigilant monitoring, routine intervention and expert management. In midwifery, women found a model that sees birth as normal, and places the strength and activity of the woman herself at the centre of the process.

Women's groups were united in their view that choices regarding childbirth should be in the hands of the mother and family and not the medical profession. For example, the Ontario Committee on the Status of Women stated:

> People must have the right to make informed choices about what they want their childbirth to be like, based on information of alternatives available. It is the parents who must raise the child and therefore they have the greatest concern for the process outcome of the birth. Pregnant women want to do what is best for their babies. Hospitals must change their focus from simply, 'getting the baby out' to provide for a good start to bonding and future parenting.

Midwives were therefore seen as being able to assist women give birth with "joy and dignity" as well as giving counselling and support for women in broader childbirth areas such as nutrition and parenting skills.

b) *Education and Entry to the Profession*

Women's groups were not in favour of a nursing prerequisite for midwifery but recommended formal, standardized midwifery education and training of midwives. For example, the Women's Perspective Advisory Committee submitted:

> We are strongly opposed to nurse only midwifery care. Nurse-midwives do indeed make fine midwives, but so do lay midwives and they must have the support to practise. We encourage the Ontario Government to help establish a program for 'certified midwives' so that the pregnant women can receive standard care under one

regulatory body.

Women's groups were certainly not in favour of excluding nurses from midwifery, but favoured a mixed entry. For example:

> N.A.C. recommends that there be a 'granny' clause to cover these midwives. They do *not* need basic midwifery training, but will have different needs for assessment and upgrading. Standardizing the academic and clinical education of present midwives for the newly legalized profession of midwifery must be carried out in the initial years following legalization. N.A.C. recommends that midwives now practising should be priorized for licensure. These midwives should continue to practise as they do now, in homes, in hospitals, and in birthing centres once they are established. A gradual phase-in program would allow for the effective integration of currently practising and foreign trained midwives.

c) *Governance of the Profession*

Women's groups were supportive of midwives having their own governing body that would not be subordinate to any other health profession. Reasons given by the women's groups for self-regulation were that midwifery is a separate profession unlike the others, that internationally midwifery is typically a self-regulating profession and that a College of Midwifery would allow for consumer input. For example, one women's group stated:

> We think that midwives must be self-regulating not only to safeguard professional autonomy but also to ensure that midwifery will always remain responsive to women's needs. We see important advantages in community representation on the midwifery governing body. There could, for example, be representatives from general groups such as the National Action Committee on the Status of Women, from the women's health movement such as the Toronto Women's Health Network, from native and immigrant women and from women with special needs such as disabled women and single mothers.

d) *Scope and Standards of Practice*

Generally the women's groups were in favour of the adoption of the international definition of midwife endorsed by the World Health Organization. The majority of submissions also felt that midwives should be the primary caregiver in normal birth although, at the choice of women, the midwife can also play a role in high risk pregnancies.

Most women's groups felt that the midwife's role should be wide enough to include birth control and family counselling, although R.E.A.L. Women of Canada specifically limited the midwives' role so as to ensure that she would have nothing to do with abortion or euthanasia.

e) *Location of Birth*

All of the women's groups were open to births taking place in hospital, in birth centers and at home. Some groups such as R.E.A.L. Women felt that while there were pros and cons to home births a good compromise would be birthing centres. Other women's groups were also in favour of alternative birthing centres but made it clear that these centres would be be an additional option for women as well as hospital or home birth.

The majority of women's groups came out strongly in favour of the home birth option. For instance, one stated:

> Home birth has been demonstrated to be a safe and beneficial alternative for low risk women, especially when supported by comprehensive emergency backup services... We therefore recommend that home birth with midwives as primary caregiver, be officially recognized as a valued option for women to choose in appropriate cases. Formal recognition is not enough. The government must also ensure that adequate emergency backup is provided by hospitals, that any intransigence by physicians is not able to subvert this option and that a comprehensive system of postnatal health perhaps modelled on Dutch maternity aids be available to all women. This type of support would also be of great importance to women who have given birth at centers or hospitals.

Many women's groups objected to the College of Physicians and Surgeons policy on home birth and that of the medical profession in general in refusing to give assistance to women who chose home birth. For instance the National Association of Women and Law objected to this paternalistic stance. They argued:

> Paternalism in the case of the normal birth is also morally unacceptable. Even if home births involved more risks than hospital births (which is far from clear) we do not allow governments or other individuals to prevent us from engaging in activities that involve risk (for instance sports). People choose to take risks for their own personal reasons. In the case of home births and midwifery, a woman typically expresses a desire to improve the quality of the home experience, to avoid unnecessary intervention and clinical atmosphere and to be able to give birth rather than "being delivered". Failure to recognize the importance of these individual wishes can only be regarded as morally unacceptable. In the absence of statistics which indicate that midwifery or home birth does not provide safe care, there is no reason to restrict women's autonomy.

Women's groups were also in favour of hospitals changing policies to be more responsive to consumer wishes. However, groups such as National Association of Women and Law and the Ontario Coalition for Abortion Clinics made it clear that these "family centred" and cosmetic changes must be in addition to the full utilization of trained midwives.

f) *Places of Practice*

Women's groups envisioned a number of options for midwives including independent practice, group practice with other midwives, multi-disciplinary group practice and employment by a health facility. Groups such as the Toronto Women's Health Network felt that in keeping with the midwifery philosophy of continuity of care and to ensure greater responsiveness to consumer needs an "on-call system is preferable to shift work".

All women's groups recommended that hospital admitting privileges should be available for midwives to facilitate care for women who wish to have their babies in the hospital.

g) *Insurance, Payment and Other Economic Issues*

Women's groups were particularly interested in midwives being paid adequately and in such a fashion that they were accessible to all women. For instance, the Toronto Women's Health Network stated the following:

> In order to ensure universal accessibility to midwifery care, the Toronto Women's Health Network recommends that midwifery be covered by the Ontario Hospital Insurance Plan for all services rendered during pregnancy, childbirth and postnatally. Midwifery services should be covered by the plan irrespective of location (e.g. rural, urban, home, birth centre, hospital) or type of practice (e.g. independent or employed by health facility).

Insurance was not seen as a major issue by the women's groups although they recommended that midwives should have access to such insurance.

Most women's groups submitted that the introduction of midwifery would be a great cost savings to Ontario people as it would result in the reduction and the use of costly medical equipment, long hospital stays, and the use of expensive highly trained medical practitioners such as obstetricians in the case of normal low risk births.

h) *Consumer Demand*

Women's groups were in agreement that there is strong consumer demand for midwifery services. For example, R.E.A.L. Women felt that midwives were in demand because women wanted their birth experience to be more family oriented and to allow fathers and other siblings to play a greater role. Women Working with Immigrant Women submitted that many immigrant women wanted the services of midwives for cultural and language reasons. Other women's groups submitted that women rejected the present system and wished access to midwives to allow women to have control over the birth experience.

III. Childbirth Groups

The Task Force received approximately 20 submissions from various childbirth education, parenting and home birth groups. All of these groups were supportive of the implementation of the independent profession of midwifery. These groups included chapters of Planned Parenthood, La Leche League of Canada and Childbirth Education Associations.

a) *Policy*

These Childbirth Groups worked directly with consumers and they listed the concerns of parents as follows:

1. fragmented care;
2. overuse of medical intervention;
3. lack of involvement of parents in decision-making;
4. lack of adequate support during labour, prenatally and after birth;
5. maternal/infant separation immediately following birth;
6. lack of choice over birth attendant, location of birth and lack of access to birthing alternatives.

These groups felt that midwifery was the solution to all these problems. Childbirth education groups in Northern Ontario believe that they have further problems due to the limited choice of medical personnel and the recent problems of doctors withdrawing from childbirth. The problems of travel and harsh weather conditions also increase stress which complicates births according to groups such as the Childbirth Education and Support Group of Thunder Bay.

b) *Education and Entry to the Profession*

Generally, a three or four year university program leading to a Bachelor of Science of Midwifery was recommended, although many groups also recommended some form of apprenticeship training.

It was felt that currently practising and non-practising but trained midwives should be assessed according to training and experience and allowances should be made for a variety of educational backgrounds. Upgrading, refresher courses and challenge exams were recommended although all should be implemented under a flexible structure. Advanced standing in all the core midwifery courses should be available for applicants from other disciplines.

Many of the groups from northern Ontario such as the Committee for Reinstating a Birthing System (CRIBS) from Nipigon recommended that a school of midwifery located in the north should be established to attract northern residents who could be trained in the north and remain in the north. Given the problem of attracting health professionals in the north, there was much support for this by childbirth groups in northern Ontario.

c) *Governance of the Profession*

All of these groups recommended that midwifery be set up as an independent self-regulating profession separate from any other health care profession. It was also recommended that midwifery legislation be designed to guard against alienating consumers who might choose other alternatives; for instance, it was recommended that there be strong consumer input structured into the College of Midwifery.

d) *Scope and Standards of Practice*

The Childbirth Education Groups recommended that the international definition of midwifery be adopted in Ontario. Some of the northern childbirth groups recommended that midwives in the north might have an even wider scope of practice to deal with the problems of inadequate nutrition, unnecessary drug use, emotional problems, isolation and lack of knowledge.

e) *Location of Birth*

The Childbirth Education Groups were perhaps the most vocal group in favour of a woman's choice as to setting of birth.

IV. Non-health Professions

In addition to the submission of the National Association of Women and Law, discussed in the Women's Group section, the Task Force received submissions from the Concerned Social Workers of Ottawa and a group of Ottawa lawyers.

Both these groups were supportive of the implementation of a self-regulating profession of midwives. The lawyers' submission recommended adopting the WHO definition of the midwife and suggested that training should be at the university level with advanced standing for those in related professions or currently practising midwives. They recommended direct entry education without a nursing prerequisite as they reasoned the "legal profession benefits from the diverse educational backgrounds and life skills of its entrants and so may the profession of midwifery".

The Concerned Social Workers of Ontario felt that midwives would have many positive effects on a family including improving parenting skills and interest. They also believed it would resolve a severe information and counselling gap for parents.

V. Other Organizations

The Task Force also received submissions from a variety of other organizations with diverse reasons for supporting midwifery.

The Ontario Federation of Labour forwarded resolutions from their 1985 Convention which supported the implementation and full funding of midwifery services.

The Union of Ontario Indians stated that at one time all their communities had practising midwives, and while they do have a group of traditional healers and midwives there is a reluctance to discuss the issue by these people "because of the present atmosphere of non-recognition in Ontario". They expressed concern that their community health representatives were not trained in birth and that there was a need for the specialized training in their communities.

8. INDIVIDUALS

I. Consumers

The Task Force received an enthusiastic response supporting midwifery from the users of the maternity health care system in Ontario; we received over 200 submissions from individual consumers. These submissions do not include the submissions received from the many consumer groups such as the various chapters of the Midwifery Task Force (representing members of the public who have used midwifery and have organized to support the implementation of midwifery), the consumers' organizations supporting home birth, the consumer groups such as nurse-consumers' organizations and general consumers' groups such as the Consumers' Association of Canada. These consumers' submissions have been covered in an earlier section.

The individual members of the public who gave written and oral submissions to the Task Force were wholeheartedly supportive of the implementation of an independent profession of midwifery that was self-regulating, yet responsive to public needs and wishes.

The submissions literally came from all corners of the province, from small villages to almost every city in Ontario as well as some submissions from out of province. They ranged from brief handwritten notes to lengthy, detailed and well-thought-out submissions. The majority were from women who wished to relate their personal birth experiences, their concerns with the present health care system and their support for midwifery. Most had experienced birth with doctors in hospitals and had then chosen to have subsequent births under the care of a midwife. With the exception of one submission, all the consumers who had used the services of a midwife related extremely positive experiences and recommended that midwifery become a legally sanctioned, viable alternative in Ontario.

a) *Policy*

Consumers recommended midwifery for a number of policy reasons. First of all, they saw the experience of giving birth as one of the most important of life experiences. As just one of the many women who made this point stated:

> The birth of our daughter was something my husband and I recall constantly with wonder and excitement. It was the greatest time of my life and I wish it could be that way for all women. I know that midwives helped make it that way.

Secondly, they felt that women and parents should have the right to control their birth experience and to have access to alternatives to the present medical/hospital experience. This rationale was repeated constantly by the consumer:

> I feel very strongly that all women have the right to choose a midwife's care as an alternative adjunct to that of a physician. The midwife sees birth as a normal process not a crisis and her training focuses on a healthy process of childbirth. Instead of being confined by medical model definitions, she works with each mother as an individual, reinforcing her confidence in her body and not interfering unless she feels reason to.

Many consumers were offended by the notion that they would make choices not in the best interest of their children and that this responsibility should be handed over to physicians. They felt that the present system took all choice out of their hands and placed the decision-making in the hands of a system which was not only impersonal but was addicted to technological intervention and this was not necessarily acting in the best interest of the mother or baby.

If the submissions received by the Task Force are any indication of the views of the general public in Ontario, dissatisfaction with the present health care system is high. Consumers indicated concern with the rising rate of high technological medical intervention which they saw as unnecessary in a normal birth. Stories such as the following were typical of the submissions:

> It was hospital policy to attach an external foetal monitor, for a 20 minute period, to women in labour. This consisted of a belt with a box placed where the foetal heartbeat was strong. I was told not to move so that it would function properly. A nurse advised me that after 20 minutes I would have to continue to wear the external foetal monitor. Who was I to argue with the necessity? I was to stay on my back for the entire period of my labour. The foetal monitor was not functioning properly and when I turned my head to look at it, one set of vital signs were often not registering. I was convinced more than once that the baby was dead or in terrible distress. Unable to move, my anxiety and pain increased.

Consumers tended to see many hospital procedures as impersonal, degrading, unnecessary and interfering with their desired birth experience. There was a strong feeling that such procedures were in the doctor's or hospital's interest, not for the benefit of the mother or child:

> They laid me flat on my back, put my feet in stirrups, and gave me a local anaesthetic and an episiotomy and used forceps to remove my son. This was *not* the natural, beautiful birth I looked forward to. This was an insult to my body and to my emotions. Everything was done so quickly, totally out of my control and almost as if I wasn't a part of what was happening. The medical staff talked to each other about what they were going to do but no one told either my husband or I.

Consumers also articulated dissatisfaction with the prenatal care currently given by most medical practitioners. Particularly, lack of information and lack of time were the biggest concerns. This submission from a couple in Kitchener-Waterloo was typical:

> It takes three months to get an appointment with an obstetrician in Kitchener-Waterloo. Given how overbooked obstetricians are, long waiting periods in the office are common, and a minimum amount of time is spent with the patient — a regular pre-natal visit would last less than 10 minutes. An insignificant amount of time is spent on discussion or education. If you find the services of your obstetrician unsatisfactory, it is virtually impossible to switch given the three month lag and the length of pregnancy.

Although the majority of consumers felt there was a place for medical intervention, they expressed a strong desire for the minimization of medical intervention in the case of the "normal birth". They generally felt that hospitals and the medical profession did not properly distinguish between normal and risky births and were unnecessarily and routinely interfering in the normal birth. One couple stated the following:

> As well as having an excessively narrow view of what is 'normal' birth, physicians seem to have an excessively liberal view of what constitutes a 'natural' birth. Prior to our son's birth, we were lulled by assurances that hospitals were open to 'natural' childbirth. Once admitted we discovered the common view seemed to be anything short of caesarean section is a 'natural' birth. 'Don't worry', the obstetrical resident said to Judith as he attached the foetal monitor's electrodes to our son's scalp, 'you'll still have your natural birth'. Frankly, we don't know what 'natural' birth is. Somewhere along the line, with the foetal monitors, I.V. drips, epidural, augmented labour, forceps, and episiotomy, our son's birth became very unnatural.

Women articulated concern for the child's health because of medical intervention and general feelings of depression and sadness because they felt the present system with its preference for epidurals, caesarean sections and other practices "robbed" them of their desired birth experience. Many women stated the present health care system made them feel inadequate.

> My first child was born in the hospital with my general practitioner. All the modern technology was used for this normal birth. I had a foetal monitor, an I.V., and ultimately an epidural, although my husband and I had prepared for 'natural birth'. The experience was disappointing, to say the least, and my husband and I resolved to do things differently the next time. Our hospital experience was typical, yet very unsatisfactory for us. I did not receive any labour support assistance from the nurses, who were apparently very busy that night. Every time someone came in to check me, approximately once an hour, it was a different nurse. And, of course, since I had an internal foetal monitor, I was on bed rest. Eventually, I asked for an epidural, and gave birth to my daughter feeling like a failure.

There was also a strong concern about the high rate of caesarean section in Ontario and many consumers who had caesarean sections felt that they were forced unnecessarily into this operation. As one woman wrote:

> I am another dissatisfied mother. Dissatisfied with the maternity care services available to the public. I am the mother of one child and expecting my second child. My first experience in birth was not a happy one. I feel I was the victim of nearly every intervention possible. I entered the hospital healthy and feeling very good, and yet I was treated as if I had a foreign illness. The foetal monitor, I.V. and bedside bars made it hard for my husband to hold my hand. Any other kind of physical comfort was impossible! The care was very impersonal; stranger after stranger wanted to 'check you'. To make a long story short, it all ended in a caesarean section which I felt and still feel was unnecessary. The decision was the doctor's. It was a decision we were forced into accepting. We were very vulnerable and feel that he used unnecessary scare tactics. If we had been educated on caesarean prevention or warned of the risks of interventions administered throughout my short labour we would have been better prepared to refuse the interventions and to battle off insistent nurses and doctors.

Dissatisfaction with lack of privacy also ran high. For example, one woman relates:

> During the actual delivery, I happened to look up and saw that there was a glass wall several feet beyond the foot of the delivery table. Beyond this wall was several students (10-15) watching the delivery. I was upset, I hadn't been asked if I minded, but again felt like I had no rights in this respect and no say in what was going on.

Similarly, consumers complained of lack of continuity in the nursing care, feeling abandoned when their doctor was not present at their birth, lack of warmth and impersonal hospital staff, not being able to move around during labour into a position most comfortable for them, not being able to drink after lengthy labours, forced to have procedures such as epidurals and episiotomies as well as poor prenatal and postnatal care by doctors and hospitals. Consumers stated that as a direct result of unhappy birth experiences, they chose midwives. One woman summed up the view of a great many consumers when she said:

> In conclusion, I could only say I personally would never again opt for a physician-assisted delivery in a hospital setting for a normal pregnancy and an expected normal delivery now that I have experienced the option of having a midwife. Outdated hospital policies and realties of physicians who do not provide continuity of care during the prenatal, labour and delivery period would once again leave me to choose a midwife.

In contrast to their stories about hospitals, consumers felt that midwives facilitated the type of birth they wanted. Midwives provided them with support and respect. A typical submission stated:

> For any woman, pregnancy is a time of profound emotional and physical change. The midwives provided me with emotional support, accurate information, and most importantly, the time to talk about my feelings and concerns. It was reassuring to know that they were available and within reach at any time.

Consumers saw midwives as providing a high quality alternative. They believed that the midwives provided a better service than what they had received with general practitioners or obstetricians. One woman said:

> I would like to talk about the difference between midwifery and traditional care at both the pre and postnatal stage. As I had mentioned I maintained pre and postnatal visits with doctors for both my children's births. Regular meetings with the midwife routinely lasted an hour. Regular appointments with the doctor took a maximum of 15 minutes (although I often waited an hour). The difference in quality of care is probably more significant than that of quantity. With the midwife I received both.

Consumers tended to view the midwife as a specialist in normal birth. Even the consumers who had hired midwives simply as a coach and as an assistant to their doctors submitted that they ended up seeing the midwife as the expert in normal birth, not the various doctors. One consumer stated:

> The midwife, like the obstetrician/gynaecologist is a specialist. She simply has a different perspective on her specialty. Her training and bias are in natural childbirth;

> her strength lies in helping low risk women birth their babies without intervention. When I categorized the medical people in my mind, it came to make more sense why I was relying more and more on the midwife; she had simply been proving herself to be a specialist.

Consumers made it very clear that they sought out the services of midwives because they were providing a role that the medical profession was not supplying by giving continuity of care, counselling and support. One couple submitted:

> Our midwife provided us with excellent professional support before conception right through to our postpartum visits. During our monthly visits, her suggestions on diet and exercise as well as our discussions on natural birthing increased both my husband's and my confidence and knowledge base to make an informed choice.

Almost every consumer's submission shared the view that the role of the midwife was unique, rather than an overlap of the services of medical or nursing practitioners.

Furthermore, midwives were often seen as a bridge between dissatisfied consumers and the present health care system. Many consumers indicated that they would only accept hospital policies or only make central decisions such as consenting to medical intervention on the advice of a midwife, because they felt that only the midwife is speaking for them and was independent of the medical profession. One woman felt that

> the midwife is going to be an important person in my birth experience. She is the only reason I agreed to go to the hospital. I know that she is not a nurse or in association with the hospital. I know I can rely on her knowledge and technique instead of listening to nurses telling me to take a pill or have a needle to relieve the 'pain'.

Consumers also felt that midwives were qualified to assess risk and to judge properly when intervention was needed. Many related stories of midwives dealing professionally with complications. One woman related an experience with a midwife where there was a complication of a cord being discovered wrapped around the baby's neck. The midwife dealt with the situation calmly by slipping off the cord without unnecessarily alarming the mother or risking the baby in any way.

Only one couple related a negative experience with a midwife, although they continue to be supporters of the midwifery profession. This Quebec couple had used the services of an Ottawa physician and an Ottawa area midwife but unfortunately the pregnancy ended in a stillbirth. The couple believe that the cause of death was gestational diabetes that had not been diagnosed by either the midwife or the doctor. The midwife believed that the doctor had done all the necessary tests and the doctor had thought the midwife had done so.

It was the recommendation of this couple that midwifery should be regulated, the education of midwives should be formalized and that the role of the physician and midwife be clearly defined to prevent such unfortunate occurrences. In their case, they blamed poor communication between the doctor and the midwife, because there was no clear delineation between the function and the responsibilities of the doctor and those of the midwife.

In summary, apart from this isolated case, the rest of the many consumers related extremely positive experiences with midwives and all recommended midwifery. Most consumers contrasted their hospital experience giving birth without midwives to the experience giving birth either at home or at hospital with midwives and felt the latter method much more satisfactory on a number of levels. While the consumers acknowledged that not all women would choose midwives, they felt that it should be an alternative available to all Ontario women.

b) *Education and Entry to the Profession*

Judging from the submissions, the consumers were unanimously in favour of multiple routes of entry to the midwifery profession. They felt strongly that midwives should not be required to become nurses as a prerequisite to being a midwife. One consumer stated:

> A system that demands a midwife first becomes a nurse seems to turn out many "midwives" that treat birth as any disease oriented medical doctor would.

Similarly, other consumers submitted:

> We have enjoyed the assistance and support of a midwife at the birth of our two children. This midwife has not been trained as a nurse, but as a midwife, and we believe that midwives should not be forced to undergo nursing training prior to being allowed to practice. Nursing training focuses on the medical model, which centers on illness, whereas the midwifery model focuses on birth as a normal process.

Many consumers went as far as submitting that they would reject a "nurse-midwifery" system and would seek out the services of a non-nurse midwife outside the system. One woman stated:

> I for one would not choose a nurse midwife in an all nurse midwifery system, because the focus is on pathology. I would feel forced to go underground to find the care I want in a non-nurse midwife.

The consumer's submissions tended not to give many details on how they would like midwives educated beyond stating they wished a mixed entry system at a midwifery school set up separate from nursing and medicine.

They further were in agreement that they wished currently practising midwives to be immediately integrated or "grandmothered" into the system. As one submission stated:

> Until there is an Ontario based educational program leading towards professional certification in midwifery, those women who have been practising the profession and striving for its legal recognition should be allowed entry into the profession ... In short I am recommending that those women who have been working as midwives be grandmothered into full legal professional status.

c) *Governance of the Profession*

Individual members of the public made many submissions on the regulation of the profession and one hundred per cent of the ones who made submissions to the Task Force were firmly committed to the recommendation that midwives be self-regulated with their own professional college, separate from nursing or medicine. The following submissions of three different consumers were typical of the consumers at large:

> Midwifery should be a completely self-regulating profession. Autonomous midwifery, not an extended role of obstetrical nurses who are called 'midwives' is needed. Midwifery in name only would not provide for the real changes in the maternity care system people are asking for.
>
> Our midwife, with her practical experience, made the delivery of our second child a rewarding experience. The fact that she was looking after my interest and she did not follow the dictums of medical practice, led to a better delivery. The fact that no episiotomy was necessary (it is usually a routine practice) because of her suggestions re: positioning during delivery is but one example why I would want midwives to be a separate governing body, removed from the medical establishment of both doctors and nurses.
>
> I feel strongly that midwifery should be a self-regulated profession. They are well-trained women who recognize their capabilities and when a situation requires the use of an obstetrician. I see them working with doctors and not working under doctors. This is the only way that consumers will get the best possible from both the midwife and the doctor. It must be a team effort.

Consumers felt that consumer input, such as structuring the College of Midwifery to have consumer members on its Board, would ensure that midwives remained responsive to consumer interests.

d) *Scope and Standards of Practice*

Consumers wanted a broad definition of midwifery, such as that set out by the World Health Organization. They articulated concerns that midwives should not be too narrowly defined in scope of practice and if this occurred they would no longer be "alternative" to the medical profession. One couple stated this concern as follows:

> We feared the Task Force would so narrowly define the profession of midwifery that midwives would be denied the right to perform simple procedures that may become necessary in a normal birth. The effect of such a narrow view would be a de facto illegalization of home births. It would also make midwives dependent upon and subservient to doctors. Further, it would not be cost effective if a midwife could catch a baby, but had to have a physician at her elbow in case the woman requires sutures. We believe, in particular that the midwife must have the right to do: amniotomies, episiotomies, suturing and administration of necessary local anaesthetics and injection of drugs after birth to aid contraction of the uterus if necessary.

Consumers saw the midwife as having a role both in the normal and the high risk birth. Many consumers recommended that midwives be allowed to assist in high risk birth especially because of their unique support role and the prenatal and postnatal counselling they provide. One woman believed that a midwife would have been helpful to her in her high risk birth. She stated a regret for allowing her obstetrician to talk her out of having a midwife in addition to his services:

> I initially talked about having a midwife for this pregnancy, but he had discouraged me from even talking to one since he said my pregnancy was too high risk. However, in hindsight I now have become aware of much of the trauma of this premature birth that could have been avoided had I the support of a midwife throughout this entire experience. Instead I had to deal with unfamiliar doctors, many different nurses, two different hospitals, and emotional stress without any support person with whom I was familiar and trusted.

e) *Location of Birth*

For many consumers the midwifery issue was tied up in the home birth issue in that they wanted choice as to location of birth as well as choice of home birth attendant. There was strong and widespread support for home birth. Only one submisison was not in favour of home birth and that was from a woman who had three hospital births, two of which she felt would have been complicated if she had chosen home birth. The remaining consumers felt that for the normal birth home birth should be an option open to women.

Although many consumers acknowledged risk with home birth, they felt that this risk was not greater than in the hospital and that it was simply risk that was site independent. They further felt that hospital births were riskier than home births because of the added risk of unnecessary medical intervention. They were also supportive of better backup services and often indicated fears that hospitals and ambulances would not assist them in an emergency because of the medical profession's policy on home birth.

Consumers who had chosen the home birth alternative indicated that they felt that this was an informed choice which did not provide great risks to the baby and was not irresponsible. One woman explained:

> Before I chose to have my first child at home, I explored the possibility of hospital birth. I took the prenatal classes and had a tour of the hospital; I spoke to my doctor about alternatives within the hospital structure. I spoke to women who had babies born at home and in the hospital. I also took the childbirth classes my midwife taught. I made a responsible decision.

Similarly, another woman submitted:

> For my second birth, I chose to put myself in an environment where no intervention and labour support were the status quo. Obviously, I had a home birth attended by a midwife. I am not part of the lunatic fringe. I did not make a choice that was described by the American College of Obstetricians and Gynaecologists as an anti-intellectual, anti-scientific revolt.

While some consumers indicated their doctors disapproved of home birth and would not provide them with their services if they chose home birth, others indicated their doctors supported them in their home birth decision. For example, one woman related:

> We agonized about this decision well into the last trimester of my pregnancy. Finally one day I asked my doctor what to do. She said 'I think a woman labours best where she is most comfortable'. Eureka! That apparently simple advice reminded me that I, like the majority of women giving birth, was low risk, that the enormous likelihood was for a problem-free birth, and that the best way to ensure that was to feel comfortable. So we decided to birth our baby at home.

Consumers reported feeling more in control and more part of the birth experience when they had a home birth. Many submitted that they felt by choosing home birth they were taking on the responsibility of the birth instead of abdicating it to others. For example, one couple stated:

> It is sad that for such a natural occurrence as a birth of baby, people are ridiculed and thought irresponsible when they decide on home birth — especially when home birth parents are definitely more in tune with the birth procedure than the average hospital parent, who gives up all responsibility and control to the hospital staff.

Consumers generally felt confident in their choice of home birth attended by a midwife, although they submitted they desired more support from the medical profession. Many felt that their labour was easier because they felt comfortable and in control of their environment.

> The labour lasted four hours; it hurt like hell, but I never panicked; I think, looking back on it, that the midwife's calm presence, and my trust in her expertise, made that possible. The quiet, calm, and peace, the sense of being in control of my own environment, all contributed enormously to the joy of my daughter's birth. I wouldn't have the baby in any other way.

Finally, consumers felt that home birth with midwives gave them the best quality birth experience with no added risk to the baby and that this experience was unavailable elsewhere. One consumer submitted:

> The birth of my son, at home, was one of the most important events in my life. To labour, to push my baby out into the world and hold him, in my own room, with his father and my midwife, friends in attendance, was an experience beyond words. I knew and trusted that both of us would be looked after and that should the need for medical attention arise, decisions would be made in our best interest.

f) *Places of Practice*

Consumers were in favour of midwifery being in practice in hospitals, in birthing centres and at home.

g) *Insurance, Payment and Other Economic Issues*

Consumers did not view the insurance problem as being of concern to them. They were concerned about the payment of midwives, both that midwives be adequately compensated and that consumers have access to public funding for midwives. In particular, OHIP coverage for midwifery was recommended strongly. Although consumers indicated that they felt that the midwife was well worth the added expense they had to pay for the midwife at the present time, they felt that public funding would increase the accessibility of midwives. One consumer summed it up as follows:

> Service which we receive from the Midwives' Collective and particularly from Vicki Van Wagner was paid for by us in full. Neither my wife nor I have ever regretted spending the money. Indeed, I feel that this service is a bargain. Unfortunately, there are many who cannot afford the fee.... I feel that for a woman to miss out on this excellent service at such a difficult and demanding time in her life.... is most unfortunate. I would like to see midwives become part of the general health care system, so that their fees could be subsidized to some degree by the province. After all, it is really in all taxpayers' best interests to have healthy babies.

Consumers also felt that midwifery would be cost effective because it would reduce expensive high technology medical intervention in the normal birth.

II. Academics

The Task Force received submissions from a number of individual Canadian academics in addition to the submissions from academics representing educational institutions or organizations that are discussed elsewhere.

1. *Dr. Mary O'Brien, Professor of Sociology, OISE*

Professor O'Brien, Sociologist, former midwife and author of *The Politics of Reproduction* wrote the Task Force recommending midwifery. She urged the Task Force to see the "social relations of birthing" and to be sensitive to birth as a personal and cultural human experience, not a medical event.

Professor O'Brien argued that the history of childbirth is not a movement from ignorance to enlightenment with the progression of medicine. In her view:

> The present concern with birthing process is not simply a stage in a long historical concern for safe childbirth. It is also part of the ongoing struggle in which women in general strive to enhance their collective human dignity as well as their sense of self. There has always been tension in male-dominated societies between the idealization of mothering and the suspicion that fecund woman has never quite managed to step from nature into history. What I remember most from my career as a midwife is the extraordinary strength of the social solidarity of women, of grandmas, aunts, neighbours, midwives united in the humanization of abstract, historical continuity.

2. *Dr. Alison Fleming, Professor of Psychology, University of Toronto*
(with others)

Alison Fleming, Diane Ruble, Vivian Anderson and Gordon Flett sent to the Task Force their research on the influence of the place of birth in birth satisfaction and mother-infant interaction. The data in their survey indicated that birth satisfaction was higher in home than in hospital births. Some differences associated with the place of birth — such as duration of early contact with the baby — affected the relationship between the mother and infant.

3. *Professor Patricia A. Kaufert and John D. O'Neill, Department of Social and Preventative Medicine, University of Manitoba*

Professors Kaufert and O'Neill wrote a lengthy submission to the Task Force outlining their findings regarding childbirth and midwifery in the Keewatin area of Northern Manitoba. Their research indicates that people living in remote northern communities, particularly Inuit people, have undergone a radical transformation from traditional midwifery nurse-midwifery, to transportation to hospitals in the south for all other births.

Their research indicates that many Inuit expressed "puzzlement" over why they were no longer allowed to birth in their own community. Justification given by medical and administrative officers for the evacuation policy was safety, questionable legality of midwives and the shortage of Canadian midwives.

These researchers concluded that the social, economic and psychological impact of evacuation on women and their families was high. Women of the north complained about the problems of being separated from their families, their loss of control in hospitals, their dissatisfaction with hospital birthing positions (would prefer traditional kneeling or standing over giving birth on their back).

According to the survey given at Eskimo Point, the ideal for most women would be to give birth in their own communities and requests were made for a return to traditional midwives or nurse-midwives. According to the researchers:

> The curtailment of traditional midwifery was seen as the loss not only of knowledge, but of a particular set of relationships which banded together people of different generations and which continued throughout life.

4. *Professor Mac Freeman, Professor of Education, Queen's University*

This professor of education was strongly in favour of the legalization of midwifery but recommended that "spiritual midwifery" be implemented. In his view midwifery had a spiritual element and that there was a sacred relationship of trust between midwives and birthing families. For this reason he was concerned about midwives being covered by OHIP insurance as he did not believe the relationship should be characterized as a "heavily insured contract".

5. *Dr. Christine Overall, Professor of Philosophy, Queen's University*

Professor Overall forwarded to the Task Force her forthcoming chapter on childbirth to be published in *Ethics and Human Reproduction: A Feminist Analysis*. Overall described her work as a critique of crucial underlying assumptions made by non-feminists and anti-feminists about the nature of childbearing itself and the relationship of the parturient woman to her foetus.

It is her view that the real conflict is between women's and medical perspective on childbirth and that the conflict between the pregnant woman and her foetus is an "invention" of the medical profession. Overall objects to the view she attributes to the Ontario Medical Association that the pregnant woman and her foetus are adversaries competing to get their needs fulfilled. Overall argues that the sacrifices that the birthing mother is expected to undergo (i.e., sacrifice of choice of location, methods and the many sacrifices inherent in hospital births) are falsely described as being for the foetus' benefit. Many of these procedures (e.g., foetal heart monitors and unnecessary immobilization) are detrimental to the foetus.

According to Overall, outside of childbirth a decision regarding risk to one person's health in order to benefit another would be seen as a moral decision, yet in childbirth decisions are falsely interpreted as being nothing more than medical choices. In Overall's view, decisions regarding childbirth are moral decisions and there are ethical problems with the assumptions that the foetus takes priority over the woman (for the woman is more than a "house" for the foetus). Furthermore it is unlikely that the woman is in competition with her foetus, as women ordinarily want the best for their future baby. If the woman and the foetus are not adversaries there is no need for the physician to intervene as the foetus' advocate to override the woman's moral decision. Overall objects not to the view that there may be cases where it is the physician's responsibility to protect the foetus from potentially unwise and self-oriented choices which may be made by a particular pregnant woman (she concedes that there may be that case but that it must be demonstrated in each particular instance) but to the assumption that the advocate for the foetus/newborn should be the doctor, not the pregnant woman/new mother. Overall argues that the decisions about birth belong primarily to the pregnant woman herself because the process is "not some isolated medical emergency but a vital part of the living of her life".

III. Other Individuals

The Task Force received submissions from two other individuals, a member of parliament and a minister, who made written submissions on behalf of the members of their communities.

Iain Angus, Member of Parliament from Thunder Bay-Atikokan, submitted that he was strongly supportive of midwifery. It was his view that the special problems of northern communities demanded the introduction of midwifery to allay the anxiety and cost of travel for non-high risk women. He further recommended a grandmothering clause to allow the midwives currently practising in northern communities to continue to do so with only the minimum interruption for refresher or upgrading programs. Furthermore, it was his view that any review of presently practising midwives should not only be an academic examination but should be geared to assessing the actual practical skills of the midwife. Moreover, northern education programs and a tuition subsidy for midwifery students who make a commitment to practising in the north should be implemented to help increase the number of midwives in northern communities.

A pastor of the Reformed Presbyterian Church in Ottawa also made a submission recommending the legal implementation of midwifery in Ontario. Pastor Richard Ganz informed the Task Force that 11 women in his congregation chose to hire midwives, either for hospital or home birth. It was his view that these women made well-educated choices and that they should have this right to choose "where, how and with whom their children will be born".

Pastor Ganz recommended that midwifery be set up as a direct entry, self regulating profession. Midwives should be covered by OHIP, have access to hospital privileges as well as the right to perform home births. He cautioned that if birthing women were not given access to the alternatives of home birth and midwifery, women would go outside the system to find these services.

9. List of Submissions*

EDUCATIONAL INSTITUTIONS

Algonquin College of Applied Arts & Technology—Margaret Sadler, Chairperson, Diane Berlett and Mary Ellen Ward.

Council of Ontario Faculties of Medicine—Dr. Fred Lowy, Chairman and K.M. Kirker, Coordinator.

Humber College—Dolena Hathaway-Hurst, Chairman, Continuation Education Nursing.

Lakehead University School of Nursing—Cynthia Loos.

Lethbridge University School of Nursing—M.R. Houston.

Mohawk College of Applied Arts & Technology—Dr. John Frid, Associate Vice-President of Health Sciences, Sharon Dore, and Kate Kemp.

Northern College, Kirkland Lake Campus—Betty Rumball, Assistant Dean of Health Sciences.

Ontario Region, Canadian Association of University Schools of Nursing (ORCAUSN)—Susan E. French, President.

Ottawa University School of Nursing—Marie Chamberlain and Christabel Kaitell, Professors.

Queen's University—Dr. R. Hugh Gorwill, Professor and Head, Department of Obstetrics and Gynaecology.

Queen's University, School of Nursing—Rita Maloney, Associate Professor.

Queen's University Student Health Service—Dr. James McSherry, Director.

Ryerson School of Nursing—Irmajean Bajnok, Chairman.

Ryerson Polytechnical Institute—Wanda Case, Education and Life Sciences Library.

St. Lawrence College—P. David.

Seneca College of Applied Arts & Technology—Mildred G. Jarvis, Acting Chairman, Health Programs, Health Sciences Division.

University of Toronto—Dr. Walter Hannah, Professor and Chairman, Department of Obstetrics and Gynaecology.

University of Toronto—Dr. A. Reid, Dr. Susan Phillips and Dr. Howard Krieger, Obstetrical Interest Group of the Family Practice Department.

University of Toronto, Working Group, Faculty of Nursing—Prof. Ellen Hodnett, Chairman.

University of Western Ontario Perinatal Outreach Program—Dr. Graham Chance and Nancy Dodman.

University of Western Ontario—Dr. J.K. Milne, Associate Professor, Obstetrics and Gynaecology.

University of Windsor—S. Cameron, Director, Associate Professor, School of Nursing and M.L. Drake.

HEALTH CENTRES AND HEALTH UNITS

First Place Community Health Centre—Dr. Brian Hutchison, Hamilton.

Middlesex—London District Health Unit—Dr. J. D. Pudden, Medical Officer of Health and Dorothy Bice, Nursing Supervisor, London.

North Western Health Unit—Gloria Alcock and Jocelyn Bruce, Kenora.

Ottawa-Carleton Regional Health Unit—Lynn Buhler, Research Officer, Ottawa.

Toronto Health Unit, The Board of Health—Roy V. Henderson, City Clerk and Maria Mandarino, Toronto.

Toronto Health Unit, The Board of Health and Department of Public Health—Dr. A. MacPherson, Medical Officer of Health, Toronto.

West Central Community Health Centre—Duncan Farnan, Director, Fiona Chapman, President, Dr. Wendell Block and Debbie Halman, Toronto.

HEALTH COUNCILS

Cochrane District Health Council—J. Atkinson, Vice-Chairman.

Grey-Bruce District Health Council, Owen Sound—G. Trolley, Executive Director.

Halton District Health Council—Bonnie Brown, Chairman.

Hamilton-Wentworth District Health Council—Robert G. Kirby, Executive Director.

Kenora-Rainy River District Health Council—Joe Brown, Executive Director.

Manitoulin-Sudbury District Health Council—Kenneth L. Hoffman, Associate Executive Director.

Metropolitan District Health Council—Brent Chambers, Executive Director.

Rideau Valley District Health Council—Robert Graham, Chairman.

Thunder Bay District Health Council—Dick O'Donnell, Chairman.

Waterloo Regional District Health Council—M. Louise Demers, Executive Director.

HOSPITALS

Brantford General Hospital—Dr. Stephen Bates.

Chedoke-McMaster Hospital—A. McPhail, Director of Nursing, Laura Snell, Sharon Dore and Dr. David Hunter.

Chedoke-McMaster Hospitals Midwifery Project—Joanne MacKenzie, Elizabeth Tuer, Helen MacDonald and Debbie Turner.

Doctors' Hospital—Dr. Brian McFarlane President and Marie Atkey, Head of Task Force on Maternal Care, Toronto.

Harper-Grace Hospitals—Cathy Collins, Coordinator of Nurse- Midwifery Services and Family Birthing Unit, Detroit.

Henderson General Hospital—McMaster University Clinic—Dr. K.G. Lamont, Chief, Hamilton.

Kingston General Hospital—Mr. Kenneth McGeorge, President and Chief Executive Officer and Dr. David Robertson.

Listowel Memorial Hospital—Dr. Frank Ellingham, Administrator.

McKellar General Hospital—Michelene Page, Manager, Labour and Delivery, Thunder Bay.

Mattawa General Hospital—Sister Therese Nolet, Executive Director.

Ottawa Civic Hospital—Kerry Marshall, Vice President, Patient Care; Gail Spindler, Planning; Pauline Murakami, Nursing Coordinator; Wendy Nicklin, Director of Nursing, Special Services; Cathy Regan, Head Nurse, Labour and Delivery; Marg Birchall, Head Nurse, Newborn Nursery.

Port Arthur General Hospital—Dr. David A. Legge, Representative for the Family Physicians.

Port Arthur General Hospital—Mrs. E. DiBlasio, Assistant Director of Nursing and Judith L. Burns, Head Nurse, Labour/Delivery.

Port Arthur General Hospital—Dr. J. Malloy, Chief of Staff and Staff Obstetrician.

St. Joseph's Family Medical Centre—Dr. G.L. Dickie, Department of Family Medicine, University of Western Ontario, London.

St. Joseph's Family Practice Unit—Dr. John Biehn, London.

St. Joseph's General Hospital of North Bay—Dr. G.J. Zeman, Dr. J.M. Jones and Dr. A.M. Pace.

St. Joseph's Hospital—Dr. Isabel Brown, Assistant Director of Nursing, Dr. E.J. Sargeant, Marg Peart and M. Sullivan, Hamilton.

St. Joseph's Hospital—Frank N. Bagatto, Executive Director and Dr. Robert Brown, Sarnia.

St. Joseph's Research Institute—Dr. J.K. Milne, Associate Professor, Obstetrics and Gynaecology, University of Western Ontario, London.

Salvation Army Grace General Hospital, Ottawa—E. Jane Bain, Obstetrical Supervisor, and Jane Crane.

Salvation Army Grace General Hospital, Scarborough—Major Harold Thornhill, Executive Director, Dr. Shelly Fruitman, Head of Obstetrics, Judity Skelton, Administrative Committee and Marilyn Bacon, Director of Nursing.

Tillsonburg District Memorial Hospital—Dr. James McDermid.

Women's College Hospital—Wendy E. Youens, Senior Vice President, Anne Rochon-Ford, Resource Coordinator of Women's Health and Dr. Jim Ruderman, Director of Family Practice and Obstetrics.

INDIVIDUALS, CONSUMERS

Aitkin, M.
Albrecht, Mrs. Carolyn R.
Amaya-Torres, Pilar and Toby Maloney.
Baird, Shirley.
Baker, Bruce & Denise.
Baker-Roberts, Teresa.
Barclay, N. K.
Bartley, Miriam
Bender, J. W.
Bertram, Mrs. Kathleen.
Birch, Brian and Mary Ellen Kappler.
Black, Lois.

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*Note: This list does not contain the list of those with whom we met in our detailed consultations, information about which is found in Chapter 1.

Blinkhorn, Ms. Mary.
Bolton, Ms. Valerie.
Bondy, Angeline.
Bonhomme, Ms. Marie.
Brazean, Ms. Sabeena.
Bremner, Marcy.
Brooks, Toby & David.
Brush, Judy Anne.
Burr, Mr. & Mrs.
Bushell, Jean.
Cappleman, Mr. & Mrs.
Cardiff, Carol.
Carter, Valence.
Cassels, Nancy R.
Catherine, Ms., The Compleat Mother.
Cavanaugh, Carol.
Cenderson, Ms. Sharon.
Chevrier, Ms. Nancy.
Chris, Mary & Paul.
Chunge, Kathleen.
Clarke, Susan.
Coll, Nancy.
Collins, Catherine.
Contreras, Carmen.
Cornelis, Jayne.
Cotton, Ann & Les Chapman.
Cox, Debora.
Cunningham, Jeff.
Cusson, Rose.
Daley, Ms. Jacqueline.
Dawn, Sharon.
Dawson, Joan.
Deorksen, Ms. Mary & Kern.
Desrosiers, Carmelle.
DeWitt, Judith & Robert Swift.
Dickson, Patricia Ann.
Dietrich, Madeline.
Diggins, Yvonne.
Dobson, Margaret.
Dorscht, Susan Rudy.
Drawson, Anne Marie.
Dunn, Lillian.
Easterbrooke, Heidi.
Eibner, Janet M.
English, Ms. Christine.
Erickson, Kim.
Evenden, Susan.
Fainstat, Dale.
Falk, K.
Fancourt, Andrea & Jean-Guy.
Feuerwerker, Alison.
Filewood, Ian.
Finnigan, Rita & Gerry Figliani and baby Elizabeth.
Ford, Clare.
Forsythe, Margaret.
Fox, Mr. & Mrs.
Franklin, Al.
Freele, Deborah.
Freeman, Marilyn.
Frey, Sharon.
Gauthier, Ms. Jane.
Gies, Cynthia M.
Girline, Cheryl & Joel.
Glover, Gary.
Goldman, Fern.
Gose, Sarah.
Goulet, Michelle.
Hackett-McNeill, Deborah.
Hale, Susan B. & Kenneth J. Hawson.
Hanson, Cindy & Dale Lakevold.
Hanson, L.
Harris, Jeanette.
Hawley, Susan.
Hay, Carol, Nick Jennings and baby Callum.
Heller, Monica & Timothy Kaiser.
Herbert, Lee.
Heyd, Barbara.
Heywood-Jones, Barbara.
Hickey, Beth.
Hill, Mrs. L.
Hoad, Simon.
Hoefs, Beverly
Howell, Brian.
Hughes, Wendy & Michael Lewis.
Hunt, Winnie.
Irwin, Lorna G.
Janson, P.
Jewett, David.
Johnson, Mr. David & Ms. Susan.
Johnson, James E.
Johnson, Ken.
Kates, Joanne.
Kavanagh, Carole.
Kavanagh, Maureen.
Kellard, Rosemarie.
Kelly, Annette.
Kemp, Ruth.
Ketonen, Miriam.
Kieran, Jane.
King, Isaiah.
Krasnichuk, Michelle.
Lace, Kathy and Hugh McKenzie and baby.
Lachane, D. F.
Laginskie, Debbie.
LeMoine, Sue.
Leroux, Kelly.
Leviton, Pamela.
Lewis, Michael & Wendy Hughes.
Livingston, Jim & Charlotte.
Locke, Sabrina.
Lovell, Kathleen D.
Lynch, Patti.
Lyons, Ms. Ann.
McArdle, Siobhan.
McDonald, Barbara J.
McDonald, Kathy.
McDonnell, Kathleen.
McIlroy, Sue.
McKeller, Elizabeth Leiss.
McKenzie, Jill.
McKercher, Douglas.
McMullan, Judy.
Maloney, Teresa.
Manjin, Mr. & Mrs.
Marek, Helen J.
Martin, Joanne.
Miller, Linda.
Minter, Lynda.
Mitchell, Irene.
Moore, Brian.
Moore, Deborah.
Morgan, Margot.
Moriarty, Mr. & Mrs.
Morisset, Catherine.
de Moura Pereira, Neize.
Munro, Georgina.
Murdock-Bailey, Babette.
Muzzerall, Lynne.
Nadon, Kim.
Nagata, Wayne & Sharon Priest.
Narayan, Rrana.
Nawlt, Michael.
Nelson, Elaine P.
O'Hearn, Peg.
Pageau, Deborah A.
Paguin, Marcelle.
Palmer, Vivianne.
Parker, Anita.
Parker, Judith M.
Patola, Tim & Pat.
Percival, David.
Perry, Barbara.
Pollar, Mary.
Pond, Paul & Dale.
Poot, Suelaine & Peter.
Pozniak, Ela B. & Paul Buchanan.
Price-Bennett, L.
Purves-Smith, Shannon.
Quinlan, Mr. & Mrs.
Racine, Elizabeth.
Redfern, E. S.
Richmond, Susan.

Robertson, A. Marian W.
Rochon-Landry, Lucie.
Roesch, Evelyn.
Ross, James V. & Anne Quick.
Ruano, Jackie.
Ruggles, Terry.
Sample, Peggy & Ken Cruikshank.
Sanders, Doris.
Schilder-Shaw, Donna.
Schottroff, Beryl.
Schwartz, Norman.
Scott, Mary.
Sentesy, H.
Seslija, Sharon.
Sheilds, Cathy.
Shell, Brian, Barbara Ostroff and baby.
Silverman, Maureen.
Sinclair, J.
Singer, Sharon & Anthony Wilson.
Smith, Carole.
Smith, Debbie.
Southworth, Kim.
Star, Pamela.
Stephenson, J. Hartley.
Steven, Jan.
Stevens, Diane.
Stobie, Thomas E., Colleen Dean and Dr. Terry and Natalie Rosen.
Stones, Mark and Ilene.
Struckett, Heather.
Szymanski, Susan.
Tanner, Frances & Richard Taylor.
Taylor, Jayne and Phillip.
Teevan, Jan.
Theriault, Darlene.
Thomson, Barbara.
Trusdale, B.
Turner, Marlene.
Umpherson, Charles.
Umpherson, Louise.
Uniac, L.
Van Kooten, Hendrika.
Verrall, Krys.
Vickers, Susan.
Vincent, Dominique.
Walters, Teresa.
Watanabe, Francine.
Weber, Nancy.
Wiebe, Helmi.
Wilks, Leo A.
Wilson, Cathy.
Wilson, Kathi.
Worley, Michelle.
Wouk, C.
Wylie, Jill.
Zenco, John.
Zuyderhoff, O. R.

INDIVIDUALS—PHYSICIANS

Baltman, Sharon.
Brown, Robert.
Fraser, J.L.
Gillett, L.E.
Hurson, J.K.
Isaac, G. H.
Kaufman, Miriam.
Lancaster, Robert D.
Legge, David.
Ludwig, John James.
Mahood-Behse, Trudi.
Mayberry, Tom.
McCourt, Catherine.
Moorhouse, C.W.
Parkin, Michael.
Van Rhijn, Peter.

INDIVIDUALS—FORM LETTERS

Arajas, Uta.
Anderson, Allan.
Baker-Roberts, Teresa.
Bentley, Nancy.
Billings, Cathy.
Borello, Mariela.
Buck, Rosemary.
Burk, Sheri.
Counsell, Kim.
Curry, Scott & Judy.
Darlington, Gerarda.
DiPersio, Karen.
Dubuc, Maureen.
Duncan, Sarah J.
Eedy, Valerie.
Hall, Sherry.
Hannah, Ann.
Hamilton, Ella.
Holman, Julian.
Holyroyd, Lisa.
Jennings, Michele.
Kennedy, Kathi.
Laidlaw, Maggie.
McDonnell, Dave.
McMullan, Judy.
Martin, Judi.
Montgomery, Agnes.
Mulholland, Diane.
Nalle, Tori.
Nathan, Kelly L.
O'Krafha, Lynda.
Obbard, Shelley.
Pearson, Laurie.
Petrie, Dawn.
Randall, Debbie.
Rieder, Ruth.
Robinson, Josephine.
Shepherd, Caroline.
Smith, Lorraine.
Sowfen, Deanna.
Staiyer, Kathy.
Stead, Gillian.
Swiss, Diana.
Wade, Leslie.
White, Caroline

INDIVIDUALS—MIDWIVES AND STUDENT MIDWIVES

Bendrick, Cathleen.
Burton, Heather.
Cannon, Peggy.
Chaunan, Usha.
Crawford, Mary.
Cressman, Elsie.
Johnson-Brophy, Edythe.
Keffer, Heather.
Kemeny, Barbara.
Kilthei, Jane.
King, Dawn.
Kleefstra, Kathleen Ash.
Kryzanauskas, Michele.
MacGillivray, Jay.
Marx, Sharon.
Mellway, Linda.
Molnar, Mary.
Nichols, Lucie.
Perez, Isabel.
Porteous, Rena.
Putt, Betty Ann.
Ropp, Violet.
Sharpe, Virginia.
Smith, Christine.
Soderstrom, Bobbi.
Teevan, Jan.

INDIVIDUALS—NURSES

Aerssen, Ruth A.
Bremner, Jane.
Cosco, Bette Jean.
Guthrie, Patricia.
Hately, Nancy.
Hurn, Linda.
King, Marion P.
Lockhart, Lynn J.
Moffat, Lynda.

Mowe, Annette.
Nafziger, Donna and R.
Nantais, Danielle.
Shrives, F..
Towes, Jane.
Walker, Myra.
Wilson, Sylvina.
Woodbeck, Heather.

INDIVIDUALS—OTHERS

Angus, Iain, M.P.
Averell, Susan.
Barnes, Rosemary.
Brona, Alice.
Coomes, Barbara A.
Dove, Alison.
Fleming, Alison.
Freeman, Mac.
Ganz, Richard L.
Gigantes, Evelyn, MPP.
Golledge, Deborah.
Johnson, Ken.
Kaufert, Patricia.
O'Brien, Mary.
Overall, Christine.
Ray, A.K.

ORGANIZATIONS, GROUPS

Childbirth Education and Birth Groups

Childbirth Education Association—Diane Laverty, Carol Burke and Leslie Viets.
Childbirth and New Parents Education Association of Sudbury Inc.—Jan Steven and Lauran Vary.
Childbirth Education and Support Group of Thunder Bay—Diane Lai & Jan Deveau.
Committee to Reinstate a Birthing System—K. Thompson, Thunder Bay.
Concerned Citizens of Chelmsford, Ontario—Serita Chiswell.
Home Birth Working Group—Susan L. Meyer, Coordinator, Will McCauley and Gary Genage, Toronto.
Kingston Childbirth Education Association—Pam Stuart.
La Leche League Canada—Cindy Butler.
London Childbirth Education Association—Kathy Frank-Freeman and Lori Gibbens.
London Home Birth Group—Jill Askin and Heather Struckett.
Planned Parenthood Ottawa—Dr. Norman Barwin.
RE: Birth—Nancy Cassels, Toronto.
Saskatchewan Association for Safe Alternatives in Childbirth (SASAC)—Barbara Scriver, Editor.
St. Jacob's Family Birthing Home—Pat Legault, Chairman, and Ankara McPherson.
Thunder Bay and District Health Coalition—P. Morton, Secretary.
Toronto Birth Centre Inc.—Karen Walker, Board of Director, M. Cheltham, Dr. Howard Krieger and C. Clarke.
VBAC Association of Ontario—Deborah Wiggins.
VBAC Parents of Ottawa—Susan Szymanski.
VBAC Support/Education Group of Kitchener/Waterloo—K. Morrison Lance and Carol Honey.

Medical and Health Groups

Association of Concerned Citizens for Preventive Medicine—Ron J. Dugas, President.
Concerned Physicians of Eastern Ontario—Dr. Gerd Schneider.
Federation of Medical Women of Canada—Dr. Kari G. Smedstad.
Michigan Board of Nursing—C. William Howe, Director.
Saskatchewan Health Policy Research and Management Services—Bev Keizer, Research Officer.
Toronto Women's Health Network—Liva Spring.
Women's Health Information Network—Judy Vinne.
Women's Health Interaction Network (W.H.I.N.)—Donna Mikeluk.

Midwifery

Alberta Association of Midwives and the Alberta Midwifery Task Force—Sandra Botting, Lethbridge.
Association of Midwives of Eastern Ontario and Its Midwifery Task Force—Betty Ann Putt, Arnprior.
Midwifery Task Force of British Columbia and British Columbia Midwifery School—Dr. Kirsten Emmott and Stan Howard, Co-chair, Vancouver.
Midwifery Task Force of Ontario—Arlene Thorne, Coordinator, S. Houston, M. Prokop, E. Driver.
    Guelph—Kay Counsell, Leslie Howarth, Susan Smith, Chris Chanter, Dave Withers and Beth Beach.
    Kenora—Susan Evenden.
    London—Anita Parker.
    Newmarket—B. Heyd and M. Dobson.
    Oshawa—Susan Hawley and Peggy Cannon.
    Ottawa—Maureen Kellerman.
    Sudbury—A. Watts et al.
Midwifery Students Group—Cathleen Bendrick, Leslie Shear et al.
Midwifery Support Group of Midwestern Ontario—Jean Schoebl, Jeanette Harris and Brigit Wolfe.
Midwives' Alliance of North America—Therese Charvet and Carol Leonard, President.
Midwives Association of British Columbia—Debra Farnsworth, President and Carol Hird.
Midwives Associaton of Canada—Lee Saxwell, Coordinator, Carol Hird and Louis Mangin.
Midwives Collective of Toronto—Elizabeth Allemang et al.
Nurse Consumers Group—Jeanne M. Lambert et al.
Toronto Nurse Consumers Group—Louise Ball et al.

Women's and Community Groups

Association of Iroquois and Allied Indians—Cathryn Wright, Health Director.
Beaches Women's Group—S. Crammond.
Carleton University Women's Centre—J. Pepper.
Concerned Social Workers of Ottawa—Allan Moscovitch and Judy Richardson.
Consumers' Association of Canada—Celia Gibbs, Chairman of Health Committee.
Council for Franco-Ontarian Affairs—Laura Gueguen-Charron, President.
Hamilton and District Council of Women—Joan De New.
London Status of Women Action Group—Julie Lee, Vice-President.
Match—Sharon Sholzberg-Gray, Executive Director.
Multicultural Women's Association—Alma Estable.
National Action Committee on The Status of Women—Kit Holmwood.
National Association of Women and the Law—Nicole Tellier.
Ontario Advisory Council on Women's Issues—Sam Ion, President, Susan MacDonald and Eva Marsewski.
Ontario Coalition for Abortion Clinics—Dr. Nikki Kolodny.
Ontario Committee on the Status of Women—D. Neville, Madeline Gilchrist and Lee Grills.
Ontario Council of the Federation of University Women—M. Towns and Barbara Blackburn.
Ontario Federation of Labour—Carol Anne Sceviour, Human Rights Director.
Ontario Federation of Students, Women's Issues Caucus—K. Jones.
Pauline McGibbon Cultural Centre—Shelagh Barrington.
Provincial Council of Women of Ontario—Donalda Broadhurst.
R.E.A.L. Women of Canada—Margaret Verkuyl and L. McNamara.
Sudbury Women's Action Group—Kirsteen Murray, President.
Sudbury Women's Centre—Maureen Hyman.
Union of Ontario Indians—Alan W. Roy, Environment Director.

University Women's Club of Ottawa—Patricia McMullen and Claire Heggtveit.

Women's Centre, University of Toronto.

Women's Perspective Advisory Committee, Liberal Party of Ontario (Midwifery Subcommittee)—Patricia Herdman, Executive Vice-Chairman, Teresa Zanatta, Chairman and Shari Bernard.

Women for Women—D. Missere.

Women of Halton Action Group—Barbara Walker, Chairperson.

Women Today, Huron County.

Women Working With Immigrant Women—A. Cioffi, S. Lucas, S. Martins, Toronto.

Professional Organizations

Association of Ontario Midwives—Rena Porteous, President.

Canadian Medical Association—Dr. J. Dyck, President.

Canadian Physiotherapy Association—Nancy Christie, Executive Director.

College of Family Physicians of Canada (Ontario Chapter)—Dr. Nick Busing, President Elect; Dr. Don Collins-Williams, Chairman; Dr. Graham Swanson, Past President, National Representative and Dr. Calvin Guttkin.

College of Nurses of Ontario—Jean Dalziel, Senior Executive Officer, Margaret Risk, Executive Director and Margaret McGovern, Chairperson of Task Force.

College of Physicians and Surgeons of Ontario—Michael Dixon, Registrar and Dr. Anthony Shardt, Associate Registrar.

Medical Reform Group of Ontario—Dr. Catherine Oliver, Dr. Brian Hutchinson.

Ontario Association of Registered Nursing Assistants—Verna Steffler, President.

Ontario Medical Association—Dr. Wilf Steinberg, Chairman, Reproductive Care Committee; John Krauser, Associate Director and Dr. Stan Lofsky, Family Physician, Hospital Privileges Committee; Dr. John Atkinson, Chairman, Hospital Committee; Dr. C. Eyjolsson, Chairman of the General Practice Committee.

Ontario Medical Association, Section on Obstetrics and Gynaecology—Dr. S. R. Panchem.

Ontario Hospital Association—Hilary Short, Director of Public Affairs, Bob Hiscock, Current Chairman, Elma Heideman, Chair-elect, Ruddy Willis, Vice-President, Member Services and Norma Clarke.

Ontario Nurses Association—Glenna Cole-Slattery, Chief Executive Officer, Marlene Babbit, Nursing Practice Officer and Donna Alexander.

Ontario Physiotherapy Association—Laura Lunn.

Ottawa-Carleton Council of Nurse Executives—Kerry Marshall, Vice President, Patient Care, Ottawa Civic Hospital.

Registered Nurses Association of Ontario—Patricia Kirkby, President, et al.

Society of Obstetricians and Gynaecologists of Canada—Dr. Knox Ritchie, Dr. D. Cudmore, President, Dr. R. Cochen, Ontario Regional Chair and Dr. Pat Mohide, Secretary.

10. Hearings

1. Ottawa—October 14, 1986

Bain, Jane and Crane, Jane—Salvation Army Grace General Hospital.

Berlett, Diane and Ward, Mary Ellen—Algonquin College of Applied Arts and Technology.

Brush, Judy Anne.

Burke, Carol and Viets, Leslie—Childbirth Education Association.

Cavanaugh, Carol.

Chamberlain, Marie and Kaitell, Christabel, Professors—School of Nursing, University of Ottawa.

Coll, Nancy E. and Jewett, David—Group of lawyers and law students.

Filewood, Ian—Canadian Council for International Cooperation.

Finnigan, Rita; Figliani, Jerry and baby Elizabeth.

Holmwood, Kit—National Action Committee on the Status of Women.

Kellerman, Maureen—The Ottawa Chapter of the Midwifery Task Force.

Lambert, Jeanne M. et al.—Nurse Consumers Group.

Maloney, Teresa.

Marshall, Kerry, Vice-President, Patient Care; Gail Spindler, Planning; Pauline Murakami, Nursing Coordinator; Wendy Nicklin, Director of Nursing, Special Services; Cathy Regan, Head Nurse—Labour and Delivery; Marg Birchall, Head Nurse—Newborn Nursery Ottawa Civic Hospital.

McMullen, Patricia and Heggtveit, Claire—University Women's Club of Ottawa.

Moscovitch, A. and Richardson, Judy—Concerned Social Workers of Ottawa.

Pepper, Jane—Carleton University Women's Centre.

Putt, Betty Ann; Soderstrom, Bobbi; Hellman, Sharon and Parkin, Diane—Eastern Branch of Ontario Association of Midwives.

Schneider, Dr. Gerd—Concerned Physicians of Eastern Ontario.

Szynanski, Susan and McLean, Sue—Midwifery and VBAC.

2. Thunder Bay—October 14, 1986

Angus, Iain, MP.—Thunder Bay-Atikokan.

Burns, Judith—Head Nurse, Labour/Delivery, Port Arthur General Hospital.

Coomes, Barbara A.—Psychologist

Dunn, Lillian.

Erickson, Kim.

Gibbs, Celia—Consumers' Association of Canada.

Kemeny, Barbara—midwife.

Ketonen, Miriam and Hoad, Simon.

Lai, Dianne—Coordinator, Childbirth Education and Support Group of Thunder Bay.

Loos, Cynthia—Lakehead University School of Nursing.

Mahood-Behse, Dr. Trudi—Family Physician.

Malloy, Dr. J.—Chief of Staff, Port Arthur General Hospital.

Maloney, Toby & Amaya-Torres, Pilar.

Marek, Helen.

Mitchell, Irene.

Morgan, Margot.

Morton, P.—Secretary, Thunder Bay District Health Coalition.

Nichols, Lucie.

Page, Michelene—McKellar General Hospital, Labour and Delivery.

Thompson, Kathy—Committee to Re-Instate a Birthing System.

Vinne, Judy—Women's Health Information Network.

Woodbeck, Heather—Clinical Instructor, Lakehead University.

3. Dryden—October 15, 1986

Alcock, Gloria and Bruce, Jocelyn—Northwestern Health Unit.

Brown, Joe—Executive Director, Kenora-Rainy River District Health Council.

Cosco, Bette Jean—Sioux Lookout, Northwest Health Unit.

Dove, Alison—Prenatal Instructor.

Evenden, Susan—Midwifery Task Force, Kenora.

Moorhouse, Dr. Cameron W.—President, Dryden Medical Society.

Schottroff, Beryl.

4. London—October 16, 1986

Bagatto, Frank N., Executive Director; and Brown, Dr. Robert—St. Joseph's Hospital, Sarnia.

Bartley, Miriam.

Bremner, Marcy.

Cressman, Elsie.

Demers, Louise—Waterloo District Health Council.

DeWitt, Judith and Swift, Robert.

Frank-Freeman, Kathy—London Childbirth Education Association.

Frey, Sharon.

Guthrie, Patricia.

Hale, Susan and Hawson, Kenneth.

Hurn, Linda.

Johnson-Brophy, Edythe.

Keffer, Heather and Kryzanauskas, Michele.

Legault, Pat—Chairman, Board of Directors; McPherson, Ankara—St. Jacobs Family Birthing Home.

Milne, Dr. J.K.—Associate Professor, Department of Obstetrics & Gynaecology, University of Western Ontario.

Palmer, Vivianne.

Schoebl, Jean; Harris, Jeanette; and Wolfe, Brigit—Midwifery Support Group of Mid-Western Ontario.

Smith, Debbie.

Steffler, Verna—President, Ontario Association of Registered Nursing Assistants.

Struckett, Heather—London Home Birth Group.

Wilson, Kathi.

Women Today of Huron County—Theatrical presentation.
[Consultation with the following—Biehn, Dr. John—St. Joseph's Hospital Family Practice Unit, Director of St. Joseph's Family Centre.
Chance, Dr. Graham and Dodman, Nancy—University of Western Ontario Perinatal Outreach Program.
Milne, Dr. Ken—St. Joseph's Research Institute, Associate Professor, Obstetrics and Gynecology, University of Western Ontario.
O'Neill, Dr. Pat—Ontario Medical Association, GP Section.]

5. Hamilton—October 20, 1986

Bates, Dr. Stephen—Brantford General Hospital.

Brown, Dr. Isabel and Peart, Marg—St. Joseph's Hospital.

Cotton, Ann and Chapman, Les.

Counsell, Kay—Midwifery Task Force of Guelph.

Crawford, Mary—Hamilton Midwifery Service.

De New, Joan—Hamilton and District Council of Women.

Frid, Dr. John—Associate Vice-President of Health Sciences; Kemp, Kate and Dore, Sharon—Mohawk College of Applied Arts and Technology.

Howarth, Leslie; Smith, Susan; Chanter, Chris; Withers, Dave and Beach, Beth—Midwifery Task Force of Guelph.

Hutchinson, Dr. Brian and Oliver, Dr. Catherine—Medical Reform Group.

Jarvis, Mildred G.—Acting Chairman, Health Programs, Seneca College of Applied Arts and Technology, Health Sciences Division.

Kleefstra, Kathleen Ash.

MacKenzie, Joanne; Tuer, Elizabeth; MacDonald, Helen and Turner, Debbie—Chedoke-McMaster Hospitals Midwifery Project.

MacPhail, Aileen; Snell, Laura; Dore, Sharon and Hunter, Dr. David—Chedoke-McMaster Hospitals

Miller, Linda.

Nagata, Wayne and Nagata, Sharon Priest.

Porteous, Rena.

Rhijn, Dr. P. Van and Heather Burton—Streetsville Medical Centre.

Sharpe, Virginia—Prepared Childbirth Training and Drop-In Centre.

Stevens, Diane.

Stones, Ilene.

Towns, Maureen and Blackburn, Barbara—Status of Women Committee of the Ontario Council of the Canadian Federation of University Women.

Walker, Barbara—Chairperson, Women of Halton Action Movement.

6. **Windsor—October 21, 1986**

Bondy, Angie.

Collins, Catherine.

Drake, M.L. and Cameron, Sheila—School of Nursing, University of Windsor.

Seslija, Sharon.

7. **Kingston—October 29, 1986**

Baird, Shirley.

Clarke, Susan.

Curry, Scott and Judy.

English, Christine; Bushnell, Jean and Racine, Elizabeth.

Fainstat, Dale and Howell, Brian.

Feuerwerker, Alison.

Freeman, Mac.

Gorwill, Dr. H.—Professor and Head, Department of Obstetrics and Gynaecology, Queen's University.

Johnson, Ken.

Kilthei, Jane.

King, Dawn.

Maloney, Rita—School of Nursing, Queen's University.

Marx, Sharon.

McSherry, Dr. James—Associate Professor, Department of Family Medicine and Director of Student Health Service, Queen's University.

Minter, Lynda.

Pancham, Dr. S.R.—Ontario Medical Association, Section on Obstetrics and Gynaecology.

Putt, Betty Ann.

Robertson, Dr. David—Kingston General Hospital.

Smith, Carole and Forsythe Margaret.

Stuart, Pam—Kingston Childbirth Education Association.

Wilson, Sylvina M.

8. **Toronto—October 6, 7, 8, 9, 10 and November 5, 1987**

Allemang, E.; Crosby, C. and Tate, M.—The Midwives Collective of Toronto.

Ball, L.; Shiplo, K.; Sloan, C. and King, J.—Nurse Consumers Group.

Barnes, Rosemary.

Bendrick, Cathleen.

Birch, Brian and Kappler, Mary Ellen.

Botting, Sandra—Alberta Association of Midwives and Midwifery Task Force.

Broadhurst, Donalda—Provincial Council of Women.

Busing, Dr. Nick—President Elect; Collins—Williams, Dr. Don—Chairman; Swanson, Dr. Graham—Past President, National Representative and Guttkin, Dr. Calvin—College of Family Physicians of Canada, Ontario Chapter.

Cannon, Peggy.

Cannon, Peggy and Hawley, S.—Oshawa Chapter of the Midwifery Task Force.

Cassels, Nancy—Re: Birth.

Cioffi, Anna and Lucas, Salome, Coordinator—Women Working With Immigrant Women.

Cole-Slattery, Glenna—Chief Executive Officer; Babbit, Marlene—Nursing Practice Officer and Alexander, Donna—Ontario Nurses Association.

Dixon, Michael—Registrar and Shardi, Dr. Anthony—Associate Registrar, College of Physicians and Surgeons of Ontario.

Farnan, Duncan—Director; Chapman, Fiona—President; Block, Dr. Wendall and Halman, Debbie—West Central Community Health Centre.

Fruitman, Dr. Shelly, Head of Obstetrics; Skelton, Judith, Administrative Committee and Bacon, Marilyn, Director of Nursing—Scarborough Grace General Hospital.

Hannah, Dr. W.—Professor and Chairman, Department of Obstetrics and Gynaecology, University of Toronto.

Hay, Carol; Jennings, Nick and baby Callum.

Herdman, P.—Executive Vice-Chairman; Zanatta, Teresa—Chairman and Bernard, Shari—Liberal Party of Ontario, Women's Perspective Advisory Committee, Midwifery Subcommittee.

Heyd, Barbara and Dobson, Marg—Newmarket Chapter of Midwifery Task Force.

Hird, Carol—Midwives Association of British Columbia.

Hird, Carol; Saxwell, Lee and Mangin, Louise—Midwives Association of Canada.

Hiscock, Bob—Current Chairman; Heideman, Elma—Chair-elect; Short, Hilary—Director—Public Affairs, Cunningham, Gordon, President; Ruddy, Willis, Vice President, Member Services and Clarke, Norma–Ontario Hospital Association.

Howard, Stan—Co-chairman, Midwifery Task Force of British Columbia and Administrator, British Columbia Midwifery School.

Jones, Kathy—Women's Commission of Ontario Federation of Students

Kates, Joanne.

Kaufman, Dr. Miriam.

Kirkby, Pat, President, McKeen, E. and Dore, Sharon—Registered Nurses Association of Ontario.

Kolodny, Dr. Nikki—Ontario Coalition for Abortion Clinics.

Leonard, Carol—President, Midwives' Alliance of North America.

Lewis, M. and Hughes, Wendy.

MacDonald, Susan and Marsewski, Eva—Ontario Advisory Council on Women's Issues.

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9. **Sudbury—November 24, 1986.**

Chiswell, Serita—Concerned Citizens of Chelmsford, Ontario.

Hoffman, Kenneth L.—Associate Executive Director, Manitoulin-Sudbury District Health Council.

Hyman, Maureen—The Sudbury's Women's Centre.

Murray, Kirsteen—President, Sudbury's Women Action Group.

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APPENDIX 3

Surveys Commissioned by the Task Force:

Norpark Computer Design (Part 1)
College of Nurses of Ontario (Part 2)

Report on
Survey of Ontario Midwives

Presented to:
Task Force on the Implementation
of Midwifery

Presented by:
Norpark Computer Design, Inc.

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Date: January 20, 1987

APPENDIX 3 (PART 1)

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All members of the Task Force helped us to understand the issues involved and the kind of information required of the survey. Ms Linda Bohnen ably coordinated our activities to ensure that the report met the needs of the Task Force.

Finally the midwives who participated in the survey made our job considerably easier by completing and returning the surveys in spite of their workloads.

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Background

Currently midwifery occupies a legally ambiguous position in Ontario. Standards have not been established regarding the qualifications necessary to practice midwifery and there do not exist formally recognized training programs. The Task Force on the Implementation of Midwifery in Ontario has been asked to recommend how midwifery should be legalized in this province.

As part of their effort to obtain information about midwives living in Ontario the Task Force commissioned a survey of midwives in Ontario who were currently practicing or were nonpracticing but were trained as midwives and were potentially able to practice midwifery when it is legalized.

The Task Force identified the following groups of interest: practicing midwives, nonpracticing midwives registered with the Ontario College of Nurses (OCN), and nonpracticing midwives not registered with the OCN. Norpark was asked to survey practicing midwives and nonpracticing midwives not registered with the OCN. The OCN was to survey nonpracticing midwives registered with OCN. Norpark and OCN were asked to coordinate their surveys so that they would be as similar as possible.

The major issues covered in the survey included: training/education; work experience; willingness to retrain; intention to practice when midwifery is legalized; and practice preferences. In addition background information about the respondents was obtained.

Method

Design of the Questionnaire

Several steps were involved in the design of the questionnaire used in the survey. First, discussions were held with members of the Midwifery Task Force as well as members of the Association of Ontario Midwives (AOM). On the basis of the advice and recommendations obtained through these discussions, a preliminary draft of the questionnaire was prepared. Second, the draft was reviewed and commented upon by a representative of the Midwifery Task Force, a representative of OCN, Environics Research Group Ltd., and a representative of AOM. Revisions were made to the questionnaire based upon these reviews. Third, the questionnaire was pilot tested on 4 midwives. The final questionnaire used in the survey is in Appendix A.

Survey Methodology and Sampling Procedures

A mail-out survey methodology was employed. The questionnaire was mailed to potential respondents along with a cover letter explaining the purpose of the survey and requesting respondents to complete and return the survey in an enclosed addressed and stamped envelope. To increase the response rate a maximum of 3 follow-up telephone calls were placed. The first call occurred 3 to 4 weeks after the questionnaire was mailed and simply reminded the respondents to complete and return the questionnaire if they had not already done so. The subsequent 2 calls, if necessary, occurred at 2-week intervals.

A total of 146 questionnaires were mailed to potential respondents. Ninety-eight were returned by mail and 4 were completed over the telephone. (Of the 102 completed questionnaires, only 100 were used in the analyses as 2 were received after the deadline date.) Twenty-one questionnaires were returned unanswered as the respondents either were not midwives or felt they were ineligible for the survey as they were nonpracticing midwives currently registered with OCN. Twenty-two questionnaires were not returned. If the 21 returned but unanswered questionnaires are subtracted from the total sample of 146, a return rate of 82% (102/125) was achieved in the survey.

Potential respondents were identified by a variety of methods. A list of practicing midwives registered with AOM was obtained and questionnaires were mailed to each person on the list. Midwives contacted in this manner were requested to provide names, phone numbers, and addresses of other midwives who they thought might be eligible for the survey. When midwives were identified who were not on the original mailing list, a questionnaire was forwarded to them. Additionally, a short description of the survey and a request for participation aimed at midwives who may not have been aware of the survey was included in the monthly newsletter of the AOM and was broadcast on the CBC radio public announcement program.

Results

Introduction and Overview

This report summarizes results from a survey of midwives living in Ontario conducted during the summer and fall of 1986. The results are summarized in the following five sections: 1) training; 2) work experience; 3) willingness to retrain and intention to practice; 4) practice preferences; and 5) biographical information.

Four different groups of midwives are included in the summary. These groups are defined by practicing versus nonpracticing (i.e., whether or not they have practiced midwifery in Ontario within the last year) and registered versus nonregistered (i.e., whether or not they were registered with the College of Nurses of Ontario).

There were 100 usable questionnaires obtained from the survey: 41 from practicing midwives (11 registered and 30 nonregistered); 34 from nonpracticing registered midwives; and 25 from nonpracticing nonregistered midwives.

Based on conversations with midwives, we estimate that there are about 50 women currently practicing midwifery in Ontario. We are unable to estimate the number of nonpracticing registered midwives in Ontario, but the College of Nurses of Ontario may well be in a position to answer this question. The nonpracticing nonregistered midwives are the least well understood group. At this point we are unable to estimate how many of these midwives live in Ontario.

It is important to try and obtain estimates of the numbers of different types of midwives because of its relevance to grandmothering. The survey results indicate that a high percentage (over 80%) of the practicing midwives (registered and nonregistered) plan to practice midwifery when it is legalized. Assuming a population estimate of 50, this suggests that at least 40 currently practicing midwives will want to practice when midwifery is legalized, although the survey suggests that there are a number of factors that will influence the decision of whether to practice such as length and cost of course, distance to the course, and pre-requisite requirements. In addition, there was concern over how midwifery was regulated and controlled once legalized. A definite preference was expressed for an independent college of midwives as opposed to inclusion in the College of Nurses.

It is not possible for us to provide even rough estimates of the number of people intending to practice midwifery for the nonpracticing groups (registered or nonregistered) because we have no estimates of their numbers in Ontario. Results from our survey indicate that about 50% of the nonpracticing registered midwives and 70% of the nonpracticing nonregistered midwives indicated that they intend to practice as a midwife when midwifery is legalized in Ontario. This latter group may be a significant consideration for grandmothering since the total population of this group may be quite large, and at least among those sampled by us, many have had considerable practical experience with midwifery and, as indicated above, intend to practice when midwifery is legalized in Ontario.

The nonpracticing respondents also indicated that the decision to practice will be influenced by such factors as length and cost of the course, distance to the course, and pre-requisite requirements. Concern over the controlling agency was not as strong as with the practicing groups.

Summary of Training

(Tables I-VII)

Practicing Registered

The majority (7/11) received some combination of midwifery and nurses training with the midwifery training lasting 1–2 years. (Five [5] of the respondents indicated they had taken a separate program for nurses training and midwifery training, while 2 indicated both that they had taken separate programs and a combined program. The latter 2 respondents may have misunderstood the option of "nursing as a pre-requisite to midwifery training.") All 7 of these respondents received their training in Great Britain (England or Scotland).

Of the remaining 4 practicing registered midwives, 1 was apprenticed-trained (in Ontario) and 2 reported self-training (1 in Ontario and 1 did not specify where the training occurred) and there was 1 "no response". Again, these 4 respondents indicated a training period of 1–2 years.

With respect to credentials obtained, 8 (of the 11) reported receiving from the organization sponsoring their program either a certificate or diploma following completion of their midwifery program, (there were 3 nonresponses) and 7 received some form of government or professional credential. Two (2) received no form of government or professional credential and 2 did not respond.

For this group, the training typically took place in a hospital (8/10) and none reported taking a refresher course lasting "two weeks or more"

Practicing Nonregistered

The most frequent methods of training for members of this group were direct-entry (9/30) or apprenticed-trained (15/30). (These numbers might be a bit higher, as the 3 "other" responses choose either a "combination of self-training and apprentice-training" or "diplomed (sic) training in Austria".) Three (3) reported "self-training". The length of the training period was reported as, generally, 2–3 years. However, there were a few respondents who indicated periods of 4 years (and 1 who reported 11 years).

With respect to credentials obtained, a large number (13/30) gave no response to the question regarding type of recognition received following completion of the midwifery program, while 14/30 received either a certificate (12/30) or a diploma (2/30). (See bottom of Table III for "other" responses.) Government or professional credentials were received by 7/30 respondents, while 16/30 reported receiving none, 4 did not respond and 3/30 reported "other".

Most of the practicing nonregistered midwives were trained by an Independent School of Midwifery (9/30) or a variety of other venues (9/30) (see Table V). A few indicated that they were trained in a hospital (3/30) or a university (1/30) and 8/30 did not respond to the question.

Most were trained in either Canada (16/30) or the U.S. (7/30), with (14/30) receiving training in Ontario. Very few (6/30) reported taking refresher courses "lasting more than 2 weeks".

Nonpracticing Registered

All members of this group reported receiving both nurses training and midwifery training: 19/34 reported the training as occurring in separate programs while 15/34 stated that nursing was a pre-requisite to midwifery training. (The majority [11/15] of this latter group received their training in Great Britain.) The average length of the midwifery component of the training was just over 1 year, however, most reported programs between 1–2 years in duration. Nearly all received a certificate or diploma (32/34) in recognition of the midwifery training and the same (32/34) obtained some form of government or professional credential.

Most received their training in a hospital (25/34) although a substantial proportion (6/34) received their training in an Independent School of Midwifery.

Like the Practicing Registered midwives, the majority were trained in Great Britain (28/34) and just over 1/3 (13/34) had taken a refresher course.

Nonpracticing Nonregistered

This group had a variety of types of training, including direct entry (13/25), midwife and nursing programs separately (7/25) or with the nursing program as a pre-requisite to the midwife program (3/25), and apprenticed-trained (2/25). The average length of training was generally reported as between 1-2 years, with some respondents ranging up to 3 years.

This group generally obtained a certificate or diploma (24/25) from the organization sponsoring their midwifery program and some form of government or professional recognition (23/25).

The training generally occurred either in a hospital (10/25) or an Independent School of Midwifery (12/25), and took place most frequently in the Philippines (14/25) followed by Europe (5/25) and Great Britain (4/25). Few (7/25) reported having taken refresher courses.

Summary of Work Experience

(Tables VIII—XV)

In terms of past experience with clients and deliveries, the estimates reported by the midwives for all groups showed tremendous variability both within and between groups. The variability in estimates could be a function of a number of factors including years of experience, location in which one practiced, possibly the era(s) during which one practiced, and the difficulty in accurately recalling one's past work load. Tables VIII and VIIIa present, respectively, the averages and frequency distribution of the estimates for number of clients and deliveries for all four groups. Two aspects of these Tables should be noted. First, not surprisingly, the practicing nonregistered midwives as a group have had the least amount of experience with clients and deliveries. This is probably attributable to their practices being located primarily in Ontario where midwifery has a legally ambiguous status and to the fact that as a group they are younger than the other three groups. Second, the nonpracticing nonregistered group have had the highest average number of clients and deliveries. The majority of the members of this group were from the Philippines and this result may reflect the common practice of midwifery in that country. (Only one member of this group reported practicing in Canada but the Province was not specified.)

As with the above data, the responses to the question on location of deliveries displayed considerable variability. The averages and frequency distributions for the estimates of locations of deliveries are shown in Tables IX and IXa. The hospital is reported to be the most frequent location for delivery by all groups and is particularly high for the practicing registered and nonpracticing nonregistered groups. All groups report having some experience with deliveries in homes, clinics, and birthing centres, with the exception that members of the practicing nonregistered groups have had almost no experience with deliveries in birthing centres.

Focussing upon the Ontario experience of the two practicing groups, there is a tendency for the nonregistered midwives to belong to a group practice more often than the registered midwives. This might reflect a continuation of the apprenticeship training which is more common amongst the nonregistered group or the tendency for members of this group to be more centrally located and therefore have more opportunity to belong to a group practice. Both of the practicing groups typically have some arrangement with a physician, although it is more common for nonregistered midwives to have some alternative informal arrangement (e.g., through the client).

The practice of midwifery does not appear to be geographically localized in Ontario. The midwives are distributed across the province with the majority of the practicing nonregistered midwives located in Central Ontario.

During the past year, both groups have had a similar number of clients (an average of about 35 per year) and deliveries (an average of about 22 per year). Deliveries have occurred in two places: the home (most frequently) and the hospital. With respect to hospital deliveries, 13 of the 30 practicing nonregistered midwives reported delivering in hospitals, and 8 reported having 10 or more deliveries in hospitals. It is not clear how to interpret this result. It may be that the midwives were reporting on attending and/or assisting the delivery rather than being technically responsible for the delivery. Or it may mean that at least in some cases practicing nonregistered midwives do deliver in Ontario hospitals.

The practicing midwives distribute their time across a variety of functions (see Table XV). Very few report spending "no" time on any of the specific functions (a maximum of 3 in each group for prenatal classes and 2 in each group for health counselling and education) and no single function stands out as receiving the majority of the midwives' time.

Summary of Willingness to Retrain and Intention to Practice When Midwifery is Legalized

(Tables XVI—XVIII)

Not surprisingly, the majority of the currently practicing midwives stated that they intend to practice midwifery when it is legalized (8/11 of the practicing registered and 28/30 of the practicing nonregistered). Only 1 practicing nonregistered stated that she didn't plan to practice. Perhaps more surprisingly, a majority of the two nonpracticing groups stated that they planned to practice; 17/33 of the nonpracticing registered and 17/24 of the nonpracticing nonregistered. Very few stated that they did not plan to practice (7/33 of the nonpracticing registered).

All groups felt that the actual decision to practice would be influenced by the length of course, cost of course, distance to course, and pre-requisite requirements. In addition, the midwives volunteered a number of other considerations which would influence their decision to practice. For the practicing midwives, especially the practicing nonregistered, independence of a college of midwives from a physician-controlled model was a concern (see Table XVII).

The nonpracticing registered group were less unified as a group, but those who did respond suggested an opposite model to the practicing groups, that is, they were concerned that a strong governing body and controls should exist with some explicit concern that it reside in the nursing/medical profession (see Table XVII).

Within the practicing groups, of those who responded, no one was unwilling to take qualifying courses which lasted 8 months (or less), and for courses of 16 months the "unsure" response increased but not the "no" response. The nonpracticing groups seemed less willing to take courses lasting 8 months or more. (Also, there were more individuals who didn't respond to this question in both nonpracticing groups).

Summary of Midwifery Practice Preferences

(Tables XIX—XXV)

In general, practicing midwives (i.e., registered and nonregistered) were similar in their attitudes toward implementation of midwifery in Ontario, options for its practice, and educational requirements. Registered nonpracticing midwives agreed with the former groups on a number of issues, although they did diverge substantially on questions of qualification (i.e., in general, the nonpracticing registered were more supportive of the role of nurses or nurses training as an important component of midwifery). The nonpracticing nonregistered group tended to be more similar to the practicing groups although they did not display the unanimity of those groups.

The practicing midwives (both registered and nonregistered) were nearly unanimous in agreeing that midwifery should be an independent profession, practiced by "qualified midwives" (as opposed to nurses), and that parents should be able to decide where and who delivers their children. They also were strongly opposed to midwifery as a nursing specialty. The nonpracticing registered midwives were divided in their support/opposition to the preceding issues, except that they strongly agreed with midwifery as a nursing specialty and were supportive of parents' rights to decide who delivered their children. In general, the nonpracticing nonregistered midwives agreed with the practicing midwives, although their support was split on the issue of whether or not midwifery should be a nursing specialty.

A number of options for the practice of midwifery were reported as acceptable in all groups, although the support for (or opposition to) specific options differed between groups. Practicing midwives (registered and nonregistered) were very favourably disposed to group practice or independent practice with a family physician; moderately favourable towards independent practice, independent practice with an obstetrician, practice in birthing centres or community clinics; and opposed to practice in either a doctor's office or hospital and group practices in which client responsibility was not one-to-one. The nonpracticing midwives were opposed to group practice without one-to-one responsibility with clients and independent practice, and gave moderate support for practices in more institutionalized settings (i.e., birthing centres, community clinics, and hospitals) or with family physicians and obstetricians.

In terms of the basic educational preparation needed for a beginning midwife, there were a few notable differences between the groups. All groups, except the nonpracticing nonregistered, gave only mixed support for the need for a college diploma. Again with the exception of the nonpracticing nonregistered who offered very little support, the remaining three groups were split on whether a B.A. degree was necessary and almost no support for a M.A. was offered by any of the four groups. A formal apprenticeship program was the preferred requirement of the practicing nonregistered group reflecting the training most of them have already had. Finally, the practicing nonregistered group volunteered the most comments regarding "other" appropriate requirements. In general, these comments argued for more informal preparatory systems such as individual assessments, credit systems, and informal apprenticeship.

Summary of Biographical Information

(Tables XXVI—XXXI)

The groups differ in average age, with the registered groups being older (practicing average age was 44.4 and the nonpracticing was 47.4) than the nonregistered groups (practicing average age was 33.8 and the nonpracticing was 37.5). In fact, 97% of the practicing nonregistered and 74% of the nonpracticing nonregistered midwives are 40 years of age or younger. The groups, as expected, differ in education. The two registered groups had RN degrees (with only 1 member of each group having an RNA degree). The practicing nonregistered had a number of members (40%) with a B.A. or B.Sc., while the nonpracticing nonregistered group had few degrees past high school. (It is possible the latter result is an indication that the degrees they hold are not recognized in Canada). The groups did not differ in marital status (approximately 67% in each group were married and 20% were single) nor employment (80-90% in each group had employment). As would be expected, the two younger groups; (the practicing nonregistered and nonpracticing nonregistered) were more likely to be primary caretakers of children (about 67% as opposed to 25% in the other two groups). The nonpracticing registered group had the highest annual income, reporting earnings between $20,000–$40,000, while the other 3 groups generally earned under $20,000.

TABLES

Table I
Type of Training Received

	Practicing		Nonpracticing	
	Registered	**Nonregistered**	**Registered**	**Nonregistered**
N	11	30	34	25
Direct Entry	1(9%)	9(30%)	0	13(52%)
Midwifery Training & Nursing Training (Separate Program)	5(45%)	0	19(56%)	7(28%)
Nurse-Midwife	2(18%)	0	15(44%)	3(12%)
Apprentice Trained Midwife	1(9%)	15(50%)	0	2(8%)
Self-Trained Midwife	2(18%)	3(10%)	0	0
Other	0	3(10%)*	0	0

* (i) combination of self-training and apprentice-training
(ii) diplomed midwife training in Austria

Table II
Average Length of Midwifery Training (Months)

	Practicing		Nonpracticing	
	Registered	**Nonregistered**	**Registered**	**Nonregistered**
N	8	28*	34	25
X =	14	22	13	19
Minimum	12	6	3	2
Maximum	24	48	30	36

* One midwife was excluded from this analysis as she reported her training as lasting 11 years.

Table III
Form of Recognition Following Completion of Midwifery Program

	Practicing		Nonpracticing	
	Registered	**Nonregistered**	**Registered**	**Nonregistered**
N	8	17	33	24
Certificate	6(75%)	12(71%)	23(70%)	8(33%)
Diploma	2(25%)	2(12%)	9(27%)	16(67%)
BA	0	0	0	0
MA	0	0	0	0
Other	0	3(17%)*	1(3%)**	0

* (i) letter verifying completion of apprenticeship
(ii) integrated midwifery into Bachelor of Independent Studies Program
(iii) received approval from various institutes—no formal papers

** (i) registration

Table IV
Form of Government or Professional Midwifery Credential Following Completion of Basic Midwifery Education

	Practicing		Nonpracticing	
	Registered	**Nonregistered**	**Registered**	**Nonregistered**
N	9	26	34	25
None	2(22%)	16(62%)	2(6%)	1(4%)
Certification	3(34%)	2(7%)	22(65%)	10(40%)
Licensure	2(22%)	3(12%)	3(9%)	7(28%)
Registration	2(22%)	2(7%)	7(20%)	6(24%)
Other	0	3(12%)*	0	1(4%)**
Do Not Know	0	0	0	0

* (i) filed informal choice with Association of Ontario Midwives
(ii) in Texas all you need to do is register at the state office
(iii) certificate for diplomed midwife

** (i) received licensure but it was not recognized as she was underage (under 21)

Table V
Type of Institution Sponsoring Midwifery Program

	Practicing		Nonpracticing	
	Registered	Nonregistered	Registered	Nonregistered
N	10	22	34	25
Hospital	8(80%)	3(15%)	25(74%)	10(40%)
College	0	0	0	0
University	0	1(5%)	2(6%)	2(8%)
Independent School of Midwifery	0	9(40%)	6(18%)	12(48%)
Other	2(20%)*	9(40%)**	1(2%)***	1(4%)****

* (i) 3 doctors
(ii) independent study; herself

** (i) Association of Ontario Midwives
(ii) apprenticed with independent midwives
(iii) health centre/missionary
(iv) Vancouver Birth Counselling Centre
(v) self

*** (i) French doctor in charge of area

**** (i) Tennessee farm

Table VI
Places Where Training Occurred

	Practicing		Nonpracticing	
	Registered	Nonregistered	Registered	Nonregistered
N	9	28	34	25
Canada	1(11%)	16(57%)	1(3%)	0
(Ontario)	1(11%)	14(50%)	0	0
Great Britain	7(78%)	2(7%)	28(82%)	4(16%)
Philippines	0	0	0	14(56%)
U.S.A.	0	7(25%)	2(6%)	1(4%)
Europe	1(11%)	2(7%)	0	5(20%)
Africa	0	0	2(6%)	1(4%)
Other	0	1(4%)*	1(3%)**	0

* (i) Guatemala

** (i) Trinidad

Table VII
Refresher Courses Following Completion of Basic Training*

	Practicing		Nonpracticing	
	Registered	Nonregistered	Registered	Nonregistered
N	10	29	33	24
Yes	0	6(21%)	13(39%)	7(29%)
No	10(100%)	23(79%)	20(61%)	17(71%)

* The question asked whether they had taken refresher courses "lasting two weeks or more".

Table VIII
Average Number of Clients and Deliveries Following Completion of Training

	Practicing		Nonpracticing	
	Registered	Nonregistered	Registered	Nonregistered
Number of Clients				
N	8	27	16	15
X	427	104	441	569
Minimum	30	0	0	0
Maximum	2000	350	2001	5000
Number of Deliveries				
N	9	27	18	18
X	410	151	171	707
Minimum	6	0	0	10
Maximum	2000	1100	1200	5000

Note: Midwives practiced for varying time periods and this is reflected in the means. Differences may or may not appear depending on whether one calculates clients and/or deliveries per length of practice time.

Table VIIIa
Number of Clients and Deliveries Following Completion of Training

	Practicing		Nonpracticing	
	Registered	Nonregistered	Registered	Nonregistered
Number of Clients				
N	8	27	16	15
0	0	2(7%)	2(13%)	1(7%)
1-100	4(50%)	17(63%)	7(43%)	9(60%)
101-200	2(26%)	3(11%)	2(13%)	2(13%)
201-500	0	5(19%)	1(6%)	1(7%)
501-1000	1(12%)	0	2(13%)	0
over 1000	1(12%)	0	2(13%)	2(13%)
Number of Deliveries				
N	9	27	18	18
0	0	2(7%)	1(6%)	0
1-100	6(67%)	15(56%)	10(56%)	10(56%)
101-200	0	5(19%)	4(22%)	3(17%)
201-500	1(11%)	3(11%)	2(11%)	1(6%)
501-1000	0	1(4%)	0	1(6%)
over 1000	2(22%)	1(4%)	1(6%)	3(17%)

Table IX
Locations Where Deliveries Occurred

	Practicing		Nonpracticing	
	Registered	**Nonregistered**	**Registered**	**Nonregistered**
Hospital				
N	10	27	19	18
X	203	76	95	593
Minimum	0	0	0	0
Maximum	1800	1070	500	4000
Clinic				
N	10	27	21	18
X	50	11	10	12
Minimum	0	0	0	0
Maximum	500	300	180	150
Birthing Centre				
N	10	27	21	18
X	63	1	34	48
Minimum	0	0	0	0
Maximum	200	20	500	800
Home				
N	10	26	21	18
X	46	54	37	42
Minimum	6	0	0	0
Maximum	155	300	201	580
Other				
N	10	27	20	18
X	0	1	1	12
Minimum	0	0	0	0
Maximum	0	12	10	200

Note: Deliveries are not restricted to Canada.

Table IXa
Locations Where Deliveries Occurred

	Practicing		Nonpracticing	
	Registered	**Nonregistered**	**Registered**	**Nonregistered**
Hospital				
N	10	27	19	18
0	3(30%)	16(59%)	5(26%)	2(11%)
1-100	5(50%)	8(30%)	8(40%)	11(61%)
101-200	1(10%)	0	3(16%)	1(6%)
201-500	0	2(7%)	3(16%)	0
501-1000	0	0	0	1(6%)
over 1000	1(10%)	1(4%)	0	3(17%)
Clinic				
N	10	27	21	18
0	9(90%)	26(96%)	18(86%)	12(67%)
1-100		0	2(10%)	5(28%)
101-200	0	0	1(4%)	1(5%)
201-500	1(10%)	1(4%)	0	0
501-1000	0	0	0	0
over 1000	0	0	0	0
Birthing Centre				
N	10	27	21	18
0	9(90%)	25(93%)	18(86%)	13(72%)
1-100	0	2(7%)	1(5%)	4(22%)
101-200	1(10%)	0	1(5%)	0
201-500	0	0	1(5%)	0
501-1000	0	0	0	1(6%)
over 1000	0	0	0	0
Home				
N	10	26	21	18
0	0	7(30%)	10(48%)	8(44%)
1-100	9(90%)	15(58%)	8(38%)	9(50%)
101-200	1(10%)	2(7%)	2(10%)	0
201-500	0	2(7%)	1(4%)	0
501-1000	0	0	0	1(6%)
over 1000	0	0	0	0
Other				
N	10	27	20	18
0	10(100%)	24(89%)	19(95%)	16(89%)
1-100	0	3(11%)	1(5%)	1(6%)
101-200	0	0	0	1(6%)
201-500	0	0	0	0
501-1000	0	0	0	0
over1000	0	0	0	0

Table X
Types of Ontario Midwifery Practices

	Practicing	
	Registered	Nonregistered
N	10	28
Group Practice	4(40%)	21(75%)
Independent Practice By Yourself	0	4(14%)
Independent Practice With Family Practitioner	4(40%)	2(7%)
Independent Practice With An Obstetrician	1(10%)	1(4%)
Employee in Doctor's Office	1(10%)	0
Employee in Birthing Centre	0	0
Employee in Clinic or Community Health Facility	0	0
Employee Working Scheduled Shifts	0	0

Table XI
Current Arrangements With Physician For Home Births

	Practicing	
	Registered	Nonregistered
N	10	29
Cooperative, Prenatal Care Only	3(30%)	6(21%)
Cooperative, Hospital Liaison and Emergency Care	5(50%)	13(45%)
Uncooperative	0	1(3%)
No Arrangement	2(20%)	2(7%)
Other	0	7(24%)*

* (i) clients have own arrangements with physicians
(ii) arrangements vary; that is, some are supportive, others not
(iii) combination of first and second options

Table XII
Location of Current Practice

	Practicing	
	Registered	Nonregistered
N	8	27
Central Ontario (Total)	3(38%)	17(62%)
Toronto	0	12(44%)
Brampton	0	1(4%)
Markham	0	2(8%)
Oshawa	0	1(4%)
Hamilton	2(25%)	1(4%)
Simcoe	1(13%)	0
Eastern Ontario (Total)	2(25%)	5(19%)
Ottawa	2(25%)	4(15%)
Perth	0	1(4%)
Southwestern Ontario (Total)	1(13%)	3(12%)
Kitchener	1(13%)	1(4%)
London	0	1(4%)
Guelph	0	1(4%)
Northern Ontario (Total)	2(25%)	2(8%)
Thunder Bay	1(13%)	1(4%)
North Bay	1(4%)	
Pickle Lake	1(13%)	0

Table XIII
Average Number of Clients and Deliveries in Ontario Practice (Per Annum)

		Practicing	
		Registered	Nonregistered
Number of Clients			
	N	8	26
	X	32	35
	Minimum	4	0
	Maximum	65	100
Number of Deliveries			
	N	7	26
	X	20	25
	Minimum	5	1
	Maximum	50	56

Table XIIIa
Number of Clients and Deliveries in Ontario Practice (Per Annum)

CLIENTS	**Practicing**	
	Registered	**Nonregistered**
N	8	26
0	0	2(8%)
1—20	3(38%)	6(23%)
21—40	3(38%)	6(23%)
41—60	1(12%)	11(42%)
61—80	1(12%)	0
81—100	0	1(4%)

DELIVERIES	**Practicing**	
	Registered	**Nonregistered**
N	7	26
0	0	0
1—10	2(29%)	4(15%)
11—20	3(43%)	9(35%)
21—30	1(4%)	6(23%)
31—40	0	0
41—50	1(4%)	5(19%)
over 50	0	2(8%)

Table XIV
Locations Where Deliveries Occurred (In Ontario)

	Practicing	
	Registered	**Nonregistered**
Hospital		
N	7	27
X	3	7
Minimum	0	0
Maximum	15	31
Clinic		
N	7	27
X	0	0
Minimum	0	0
Maximum	0	0
Birthing Centre		
N	7	27
X	0	0
Minimum	0	0
Maximum	0	0
Home		
N	7	27
X	19	29
Minimum	0	1
Maximum	50	295
Other		
N	7	27
X	0	0
Minimum	0	0
Maximum	0	0

Table XIVa
Locations Where Deliveries Occurred (In Ontario)

Hospital	Practicing	
	Registered	Nonregistered
N	7	27
0	5(71%)	14(52%)
1—10	1(14%)	6(22%)
11—20	1(14%)	3(11%)
21—30	0	3(11%)
31—40	0	1(4%)
41—50	0	0
over 50	0	0

Clinic	Practicing	
	Registered	Nonregistered
N	7	27
0	7(100%)	27(100%)
1—10	0	0
11—20	0	0
21—30	0	0
31—40	0	0
41—50	0	0
over 50	0	0

Birthing Centre	Practicing	
	Registered	Nonregistered
N	7	27
0	7(100%)	27(100%)
1—10	0	0
11—20	0	0
21—30	0	0
31—40	0	0
41—50	0	0
over 50	0	0

Table XIVa (cont'd)
Locations Where Deliveries Occurred (In Ontario)

Home	Practicing	
	Registered	**Nonregistered**
N	7	26
0	1(14%)	0
1—10	1(14%)	6(23%)
11—20	3(43%)	12(46%)
21—30	1(14%)	5(19%)
31—40	0	1(4%)
41—50	1(14%)	2(8%)
over 50	0	0

Other	Practicing	
	Registered	**Nonregistered**
N	7	27
0	7(100%)	27(100%)
1—10	0	0
11—20	0	0
21—30	0	0
31—40	0	0
41—50	0	0
over 50	0	0

Table XV
Percentage of Time Spent Performing Major Midwifery Functions in Ontario

	Pregnancy Care		Prenatal Classes		Labour Care Without Delivery	
	P/R*	P/NR**	P/R	P/NR	P/R	P/NR
N	9	24	9	24	8	23
0%	1(11%)	0	3(34%)	3(13%)	1(13%)	1(4%)
1-10%	1(11%)	2(8%)	3(34%)	16(66%)	2(25%)	6(26%)
11-20%	3(34%)	4(17%)	1(11%)	3(13%)	2(25%)	12(53%)
21-30%	2(22%)	7(30%)	2(22%)	1(4%)	2(25%)	3(13%)
31-40%	0	8(33%)	0	0	0	0
41-50%	1(11%)	1(4%)	0	1(4%)	0	0
51-60%	1(11%)	1(4%)	0	0	0	1(4%)
61-70%	0	0	0	0	1(13%)	0
71-80%	0	1(4%)	0	0	0	0
81-100%	0	0	0	0	0	0

	Labour Care With Delivery		Care for New Mother		Care for Newborn and Infant	
	P/R	P/NR	P/R	P/NR	P/R	P/NR
N	9	24	9	23	9	24
0%	1(11%)	0	2(22%)	0	2(22%)	0
1-10%	1(11%)	8(33%)	5(56%)	18(78%)	6(67%)	18(75%)
11-20%	1(11%)	6(25%)	1(11%)	3(13%)	1(11%)	5(21%)
21-30%	2(22%)	9(38%)	1(11%)	2(9%)	0	1(4%)
31-40%	3(34%)	1(4%)	0	0	0	0
41-50%	0	0	0	0	0	0
51-60%	0	0	0	0	0	0
61-70%	1(11%)	0	0	0	0	0
71-80%	0	0	0	0	0	0
81-100%	0	0	0	0	0	0

	Family Planning		Health Counselling and Education	
	P/R	P/NR	P/R	P/NR
N	9	22	8	22
0%	1(11%)	3(14%)	2(25%)	2(9%)
1-10%	8(89%)	18(82%)	4(50%)	17(78%)
11-20%	0	0	2(25%)	1(4%)
21-30%	0	1(4%)	0	2(9%)
31-40%	0	0	0	0
41-50%	0	0	0	0
51-60%	0	0	0	0
61-70%	0	0	0	0
71-80%	0	0	0	0
81-100%	0		0	0

* Practicing, Registered Midwives ** Practicing, Nonregistered Midwives

Table XVI
Intention to Practice as a Midwife When Midwifery is Legalized in Ontario

	Practicing		Nonpracticing	
	Registered	Nonregistered	Registered	Nonregistered
N	11	30	33	24
Yes	8(73%)	28(94%)	17(52%)	17(71%)
No	0	1(3%)	7(21%)	0
Uncertain	3(27%)	1(3%)	9(27%)	7(29%)

Table XVII
Importance of Qualifying Course Factors In Influencing Decision to Practice

	Practicing		Nonpracticing	
	Registered	Nonregistered	Registered	Nonregistered
Length of Course				
N	11	30	31	24
Important	9(82%)	25(83%)	26(84%)	22(92%)
Not Important	2(18%)	5(17%)	3(10%)	1(4%)
Undecided	0	0	2(6%)	1(4%)
Cost of Course				
N	11	30	31	24
Important	9(82%)	27(90%)	22(71%)	19(79%)
Not Important	2(18%)	3(10%)	7(23%)	4(17%)
Undecided	0	0	2(6%)	1(4%)
Distance to Course				
N	11	30	31	24
Important	11(100%)	28(93%)	27(87%)	23(96%)
Not Important	0	2(7%)	3(10%)	0
Undecided	0	0	1(3%)	1(4%)
Pre-requisite Requirements				
N	11	30	30	23
Important	9(82%)	28(93%)	29(97%)	21(92%)
Not Important	2(18%)	2(7%)	1(3%)	1(4%)
Undecided	0	0	0	1(4%)
Other Factors				
N	11	30	34	25
None	6(55%)	10(33%)	23(68%)	21(84%)
1-2 Factors	2(18%)	17(57%)	9(26%)	3(12%)
3 Factors	3(27%)	1(3%)	1(3%)	1(4%)
4-5 Factors	0	2(7%)	1(3%)	0

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Table XVII (cont'd)

Examples of Other Factors:

Practicing, registered: (i)autonomy; freedom to practice in a variety of settings; (ii)forcing the number of births/month; if they forbid home birth; if insurance is too high; (iii)provision for medical and hospital back-up; (iv)college or university degree not required; refresher courses every 5-7 years especially if practicing

Practicing, nonregistered: (i)exact parameters of legislation very important; (ii)degree of independence of the college; midwifery model vs. physician controlled; (iii)quality of course; (iv)continuity of practice while qualifying; taking courses in area of specialties as opposed to starting at beginning; (v)relations with physicians; (vi)ability to set midwifery standards; degree of respect; scope of practice in accord with international definition; (vii)who teaches course; (viii)preservation of "grass roots" skills; whether midwifery is under control of OCN—unadvisable; parental choice of place of birth; (ix) course control; (x)daily/weekly time committment of course

Nonpracticing, registered: (i)what one would obtain following course completion; (ii)cooperation with related health care teams; (iii)strong governing body with enforced rules and regulations; midwives should be nurses first; (iv)quality of program; levels and qualifications of instructors; (v)where and under what conditions I can practice; (vi)good doctor and midwife relation

Nonpracticing, nonregistered: (i)high school diploma required; (ii)how much previous training is given credit; (iii)course taught by midwives only

Table XVIII
Willingness to Take Course of Various Time Length

	Practicing		Nonpracticing	
	Registered	Nonregistered	Registered	Nonregistered
4 Months				
N	11	25	22	18
Yes	10(91%)	22(88%)	18(82%)	17(94%)
No	0	0	1(4%)	0
Unsure	1(9%)	3(12%)	3(14%)	1(6%)
8 Months				
N	7	24	15	14
Yes	6(86%)	18(75%)	5(33%)	5(36%)
No	0	0	4(27%)	2(14%)
Unsure	1(14%)	6(25%)	6(40%)	7(50%)
16 Months				
N	7	23	14	13
Yes	2(29%)	12(52%)	2(14%)	3(23%)
No	1(14%)	1(4%)	7(50%)	4(31%)
Unsure	4(57%)	10(44%)	5(36%)	6(46%)

Table XIX
Statements Regarding Midwifery and its Implementation in Ontario

	Practicing		Nonpracticing	
	Registered	Nonregistered	Registered	Nonregistered
Independent Profession				
N	10	30	32	24
Agree	10(100%)	30(100%)	22(69%)	22(92%)
Disagree	0	0	8(25%)	2(8%)
No Opinion	0	0	2(6%)	0
Nursing Specialty				
N	11	30	34	22
Agree	3(27%)	0	31(91%)	14(64%)
Disagree	8(73%)	30(100%)	2(6%)	8(36%)
No Opinion	0	0	1(3%)	0
Qualified Midwives Not Nurses Should Practice				
N	11	30	33	25
Agree	10(91%)	30(100%)	12(36%)	24(96%)
Disagree	0	0	17(52%)	1(4%)
No Opinion	1(9%)	0	4(12%)	0
Qualified Midwives Not Nurses Should Deliver Babies in Hospital				
N	11	30	34	24
Agree	10(91%)	30(100%)	15(44%)	22(92%)
Disagree	0	0	15(44%)	1(4%)
No Opinion	1(9%)	0	4(12%)	1(4%)
Qualified Midwives Not Nurses Permitted to Conduct Home Births				
N	11	30	34	24
Agree	10(91%)	30(100%)	15(44%)	21(88%)
Disagree	1(9%)	0	17(50%)	3(12%)
No Opinion	0	0	2(6%)	0
Parents Have Right to Decide Child's Birth Place				
N	11	30	34	25
Agree	10(91%)	30(100%)	23(68%)	23(92%)
Disagree	1(9%)	0	9(26%)	2(8%)
No Opinion	0	0	2	0

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Table XIX Cont'd

	Practicing		Nonpracticing	
	Registered	**Nonregistered**	**Registered**	**Nonregistered**
Parents Have Right to Decide Who Will Assist At Child's Delivery				
N	11	30	34	24
Agree	10(91%)	30(100%)	29(85%)	23(96%)
Disagree	1(9%)	0	3(8%)	1(4%)
No Opinion	0	0	2(6%)	0

Table XX
Different Options for the Practice of Midwifery

	Practicing		Nonpracticing	
	Registered	**Nonregistered**	**Registered**	**Nonregistered**
Group Practice — Individual Midwives With Individual Clients				
N	11	30	31	25
In Favor	11(100%)	27(91%)	18(58%)	19(76%)
Opposed	0	1(3%)	4(13%)	1(4%)
Undecided	0	2(6%)	9(29%)	5(20%)
Group Practice — Group of Midwives with Group of Clients				
N	11	30	33	22
In Favor	3(27%)	10(33%)	7(21%)	11(50%)
Opposed	7(64%)	13(43%)	16(48%)	4(18%)
Undecided	1(9%)	7(24%)	10(31%)	7(32%)
Independent Practice				
N	11	28	34	24
In Favor	6(55%)	15(53%)	4(12%)	9(38%)
Opposed	3(27%)	10(36%)	23(68%)	7(29%)
Undecided	2(18%)	3(11%)	7(20%)	8(33%)
Independent Practice With Family Practitioner				
N	11	30	33	24
In Favor	10(91%)	23(77%)	24(73%)	21(88%)
Opposed	1(9%)	3(10%)	6(18%)	2(8%)
Undecided	0	4(13%)	3(9%)	1(4%)

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Table XX Cont'd

	Practicing		Nonpracticing	
	Registered	**Nonregistered**	**Registered**	**Nonregistered**
Independent Practice With Obstetrician				
N	11	29	34	24
In Favor	7(64%)	16(55%)	24(70%)	21(88%)
Opposed	2(18%)	8(28%)	5(15%)	3(12%)
Undecided	2(18%)	5(17%)	5(15%)	0
In Doctor's Office As an Employee				
N	11	30	34	25
In Favor	4(36%)	4(3%)	12(35%)	15(60%)
Opposed	6(55%)	19(63%)	15(44%)	4(16%)
Undecided	1(9%)	7(34%)	7(21%)	6(24%)
In Birthing Centre As an Employee				
N	11	29	34	24
In Favor	9(82%)	14(48%)	27(79%)	18(74%)
Opposed	1(9%)	8(28%)	4(12%)	3(13%)
Undecided	1(9%)	7(24%)	3(9%)	3(13%)
In Clinic or Community Health Centre As an Employee				
N	11	29	33	24
In Favor	7(64%)	14(48%)	21(64%)	19(79%)
Opposed	2(18%)	7(24%)	5(15%)	2(8%)
Undecided	2(18%)	8(28%)	7(21%)	3(13%)
Hospital Employee Working Scheduled Shifts				
N	11	30	33	24
In Favor	1(10%)	6(20%)	18(55%)	15(63%)
Opposed	5(45%)	24(80%)	4(12%)	4(17%)
Undecided	5(45%)	0	11(33%)	5(20%)

Table XXI
Different Methods of Payment

	Practicing		Nonpracticing	
	Registered	**Nonregistered**	**Registered**	**Nonregistered**
Salary				
N	10	29	29	21
In Favor	6(60%)	14(48%)	25(86%)	16(76%)
Opposed	3(30%)	2(7%)	2(7%)	2(10%)
Undecided	1(10%)	13(45%)	2(7%)	3(14%)
Fee for Service Paid Directly by Client				
N	10	30	27	19
In Favor	1(10%)	15(50%)	1(4%)	11(58%)
Opposed	8(80%)	12(40%)	16(59%)	6(32%)
Undecided	1(10%)	3(10%)	10(37%)	2(10%)
Fee for Service Covered by OHIP				
N	11	30	33	22
In Favor	11(100%)	29(97%)	27(82%)	17(77%)
Opposed	0	0	2(6%)	2(9%)
Undecided	0	1(3%)	4(12%)	3(14%)

Table XXII
Number of Clients Per Year if in Independent or Private Practice

	Practicing		Nonpracticing	
	Registered	**Nonregistered**	**Registered**	**Nonregistered**
N	11	30	29	23
Not Interested	0	1(3%)	6(21%)	6(26%)
Less Than 25 Cases	1(9%)	3(10%)	2(7%)	3(13%)
25—49 Cases	7(64%)	9(30%)	6(21%)	2(9%)
50—99 Cases	1(9%)	17(57%)	4(14%)	3(13%)
More Than 100 Cases	1(9%)	0	4(14%)	1(4%)
Don't Know	1(9%)	0	7(23%)	8(35%)

Table XXIII
Plans to Practice and Location of Practice When Midwifery Is Legalized in Ontario

	Practicing		Nonpracticing	
	Registered	Nonregistered	Registered	Nonregistered
N	11	30	34	25
Plan to Practice	9(82%)	25(83%)	18(53%)	16(64%)
Don't Plan to Practice	0	1(3%)	7(21%)	0
Unsure	2(18%)	4(14%)	9(26%)	9(36%)
N	10	26	13	12
Central Ontario	3(30%)	14(53%)	2(16%)	8(66%)
Toronto	1(10%)	9(35%)	1(8%)	7(58%)
Brampton	0	1(4%)	0	0
Markham	0	1(4%)	0	0
Mississauga	0	0	1(8%)	1(8%)
Oshawa	0	2(8%)	0	0
Hamilton	2(20%)	1(4%)	0	0
Eastern Ontario	2(20%)	7(27%)	4(32%)	2(16%)
Ottawa	2(20%)	5(19%)	1(8%)	1(8%)
Peterborough	0	0	1(8%)	0
Perth	0	1(4%)	0	0
Smith Falls	0	0	0	1(8%)
Kingston	0	0	2(16%)	0
Kemptville	0	1(4%)	0	0
Southwestern Ontario	3(30%)	3(12%)	2(16%)	1(8%)
Kitchener	2(20%)	1(4%)	0	1(8%)
London	0	1(4%)	0	0
Guelph	0	1(4%)	0	0
Windsor	0	0	1(8%)	0
Stratford	0	0	1(8%)	0
Brunner	1(10%)	0	0	0
Northern Ontario	2(20%)	2(8%)	5(38%)	1(8%)
Thunder Bay	1(10%)	1(4%)	3(22%)	1(8%)
North Bay	0	1(4%)	0	0
Mindemoya	1(10%)	0	0	0
Kenora	0	0	2(16%)	0

Table XXIV
Basic Appropriate Educational Preparation for a Beginning (Entry Level) Midwife

	Practicing		Nonpracticing	
	Registered	**Nonregistered**	**Registered**	**Nonregistered**
N	11	30	34	22
Diploma from College				
Yes	5(45%)	12(40%)	14(41%)	16(73%)
No	6(55%)	18(60%)	20(59%)	6(27%)
Baccalaureate Degree from University or Ryerson				
Yes	6(55%)	15(50%)	20(59%)	4(18%)
No	5(45%)	15(50%)	14(41%)	18(82%)
Masters Degree from University				
Yes	1(9%)	1(3%)	3(9%)	1(5%)
No	10(91%)	29(97%)	31(91%)	21(95%)
Formal Apprenticeship Program				
Yes	3(27%)	22(73%)	13(38%)	9(41%)
No	8(73%)	8(27%)	21(62%)	13(59%)
Other				
Yes	1(9%)	12(40%)	7(21%)	3(14%)
No	10(91%)	18(60%)	27(79%)	19(86%)

Examples of Other:

Practicing, registered: (i)special midwifery school of training

Practicing, nonregistered: (i)high school is sufficient; (ii)individual assessment; (iii)informal apprenticeship and correspondence courses; (iv)combination of college diploma and formal apprenticeship; (v)credit system; (vi)recognized formal foreign training; (vii)college of midwives

Nonpracticing, registered: (i)registered nurse and midwifery theory and practice in hospital; (ii)hospital oriented; (iii)midwifery school; (iv)certificate from birthing centre

Nonpracticing, nonregistered: (i)school of midwifery; (ii)high school and right personality

Table XXV
Attitudes Regarding Training and Performing of Various Procedures By Midwives

	Practicing		Nonpracticing	
	Registered	Nonregistered	Registered	Nonregistered
Use a Vacuum Extractor				
N	11	26	30	20
Yes	4(36%)	17(65%)	8(27%)	4(20%)
No	7(64%)	9(35%)	22(73%)	16(80%)
Use Forceps				
N	11	26	30	20
Yes	1(9%)	7(27%)	9(30%)	4(20%)
No	10(91%)	19(73%)	21(70%)	16(80%)
Perform Episiotomy				
N	11	30	32	23
Yes	11(100%)	30(100%)	31(97%)	21(91%)
No	0	0	1(3%)	2(9%)
Repair Episiotomy or Skin Laceration				
N	11	30	32	24
Yes	11(100%)	30(100%)	31(97%)	22(92%)
No	0	0	1(3%)	2(8%)
Initial Assessment of Newborn				
N	11	30	33	23
Yes	11(100%)	30(100%)	33(100%)	23(100%)
No	0	0	0	0
Intubate Newborn				
N	10	25	31	22
Yes	9(90%)	18(72%)	24(77%)	14(64%)
No	1(10%)	7(27%)	7(23%)	8(36%)
Perform Amniotomy				
N	11	30	31	22
Yes	8(73%)	27(90%)	20(65%)	15(68%)
No	3(27%)	3(10%)	11(35%)	7(32%)
Administer Local Anesthesia				
N	11	29	32	24
Yes	11(100%)	29(100%)	28(88%)	18(75%)
No	0	0	4(12%)	6(25%)

(continued on following page...)

Table XXV Cont'd

	Practicing		Nonpracticing	
	Registered	**Nonregistered**	**Registered**	**Nonregistered**
Prescribe Common Medications				
N	11	30	31	23
Yes	10(91%)	25(83%)	28(90%)	11(48%)
No	1(9%)	5(17%)	3(10%)	12(52%)
Order Common Diagnostic Procedures				
N	11	30	30	22
Yes	11(100%)	30(100%)	26(87%)	12(55%)
No	0	0	4(13%)	10(45%)

Table XXVI
Age

	Practicing		Nonpracticing	
	Registered	**Nonregistered**	**Registered**	**Nonregistered**
N	11	30	33	23
X	44.4	33.8	47.3	37.5
Age Ranges				
25-30	0	9(30%)	2(6%)	6(26%)
31-35	2(18%)	12(40%)	1(3%)	5(22%)
36-40	2(18%)	8(27%)	8(24%)	6(26%)
41-45	2(18%)	0	3(9%)	2(8%)
46-50	3(27%)	1(3%)	9(27%)	1(4%)
51-55	1(9%)	0	2(6%)	1(4%)
56-60	1(9%)	0	4(12%)	1(4%)
61-65	0	0	3(9%)	1(4%)
66+	0	0	1(3%)	0

Table XXVII
Degrees from Educational Institutions

	Practicing		Nonpracticing	
	Registered	Nonregistered	Registered	Nonregistered
N	11	30	32	25
High School	7	27	27	22
BA/BSC	2	12	0	1
BScN	1	0	0	1
RNA	1	0	1	0
RN	9	1	29	3
MA/MSc	1	0	2	1
Other*	7	15	26	18

Note: The question requested a "yes" or "no" response. The "yes" responses are recorded in the above Table.

*(1) **Practicing, registered**—other was typically a state certified midwife (5/7).

(2) **Practicing, nonregistered**—most responses were related to midwifery (e.g., certified childbirth educator, lactation consultant, midwife diploma/certificate) or were health-related (e.g., CPR, health care aid, certificate in community medicine)

(3) **Nonpracticing, registered**—most responses referred either to State Certified Midwife (13/26) or nurse-related training (e.g., State Registered Nurse, outpost nurse, District Health Nurse) (7/26) and the remaining responses referred to a health-related activity (e.g., diploma in coronary care, nursing administration)

(4) **Nonpracticing, nonregistered**—most referred to simply "midwifery" or State Certified Midwife (11/18) and to health care aid (5/18).

Table XXVIII
Marital Status

	Practicing		Nonpracticing	
	Registered	Nonregistered	Registered	Nonregistered
N	11	30	33	25
Single	2(18%)	5(17%)	10(30%)	3(12%)
Married	9(82%)	17(57%)	21(64%)	20(80%)
Separated	0	4(13%)	0	1(4%)
Divorced	0	2(6%)	2(6%)	0
Widowed	0	0	0	1
Other	0	2(6%)	0	0(4%)

Table XXIX

Primary Caretaker of Children

	Practicing		Nonpracticing	
	Registered	**Nonregistered**	**Registered**	**Nonregistered**
N	11	30	32	24
Yes	6(55%)	20(67%)	8(25%)	17(71%)
No	5(45%)	10(33%)	24(75%)	7(29%)

Table XXX

Employment

	Practicing		Nonpracticing	
	Registered	**Nonregistered**	**Registered**	**Nonregistered**
N	11	29	32	24
Yes	9(82%)	25(86%)	31(97%)	20(83%)
No	2(18%)	4(14%)	1(3%)	4(17%)

Table XXXI

Annual Income (Last Year)

	Practicing		Nonpracticing	
	Registered	**Nonregistered**	**Registered**	**Nonregistered**
N	11	27	31	19
under $10,000	2(18%)	16(59%)	3(10%)	5(26%)
$10,000-$20,000	6(55%)	10(37%)	2(6%)	12(63%)
$20,000-$30,000	2(18%)	0	12(39%)	2(11%)
$30,000-$40,000	1(9%)	0	10(32%)	0
$40,000-$50,000	0	1(4%)	4(13%)	0

to Norpark Report on Survey of Ontario Midwives

Name ____________________

Phone Number ____________________

Subject Number ____________________

Date ____________________

Hello, is this ____________________ ?
I'm ____________ from Norpark. We are conducting a survey of practicing and non-practicing midwives living in Ontario to ask about your training and experience as a midwife, and how you think midwifery should be practiced in Ontario. Your answers will be kept confidential.

We are conducting this survey for the Task Force on the Implementation of Midwifery, and the Association of Ontario Midwives fully supports this survey. The Task Force will use this survey to recommend a framework for the education of midwives and the practice of midwifery in Ontario. We will treat your answers confidentially.

This survey is trying to reach non-practicing midwives not registered with the College of Nurses, and practicing midwives. If you are a non-practicing midwife registered with the College, we cannot interview you; but you may be contacted by the College which is conducting a similar survey. Although if you know of someone whom you think we should interview, we would appreciate their name, address and phone number.

The interview will take about 45 minutes. Please feel free to interrupt me; and if I ask a question you don't want to answer, you don't have to.

Were you trained as a midwife? ____ yes ____ no

Are you currently practicing or have you practiced midwifery in Ontario in the last year?

____ yes ____ no

Are you currently registered as a nurse or nursing assistant with the College of Nurses of Ontario?

____ yes ____ no

Subject number ____________

Training

The first section deals with your training as a midwife.

1. Which phrase best describes the type of training you received?

   ____ direct entry midwife (formally trained non-nurse midwife)

   ____ midwifery training and nursing training (separate programs)

   ____ nurse-midwife (nursing a pre-requisite to midwifery training)

   ____ apprentice-trained midwife

   ____ self-trained midwife

   ____ other (please specify)

2. How long was your training? If your program combined nursing and midwifery training, how long was the midwifery portion of that program?

   ____ months

3. When did you complete your basic midwifery training? Where?

   ____ year ____________ country (PROV., IF CANADA)

4. During your training, approximately how many clients did you follow through the entire pregnancy cycle (during pregnancy, labor, and in the postpartum period)?

   ____ clients ____ don't know

5. During your training, how many babies were you required to deliver (not just observe)?

   ____ births

6. I will read a number of places where the babies might have been born. After I read each location, please tell me approximately how many babies you delivered there during your training?

   hospital? ____
   clinic? ____
   birthing center? ____
   home? ____
   other? ____

7. I am going to read a number of functions midwives perform. For each function tell me approximately how many weeks during your training you spent performing it?

   pregnancy care (individual attention to clients) ____ weeks
   prenatal classes ____ weeks
   labor care (excluding delivery) ____ weeks
   labor care (including delivery) ____ weeks
   care for the new mother ____ weeks
   care for newborn and infant ____ weeks
   family planning ____ weeks

8. At the end of the midwifery program did you receive one of the following forms of recognition from the organization sponsoring the program?

____ certificate

____ diploma

____ BA

____ MA

____ other (please specify) ____________________

9. At the end of your basic midwifery education, did you obtain one of the following forms of government or professional midwifery credentials?

____ Did not obtain a government or professional midwifery credential

____ certification

____ licensure

____ registration

____ other (please specify) ____________________

____ do not know

10. What type of institution sponsored the program?

____ hospital

____ college

____ university

____ independent school of midwifery (independent of other institutions)

____ other (please specify) ____________________

11. Have you taken any courses lasting two weeks or more, including refresher courses in midwifery, after finishing your basic training?

____ no ____ yes

(IF YES, PLEASE ASK:)

____________________ the course or program name

____ degree or certificate obtained

____ the duration of the course

____ the year you finished it

____________________ the course or program name

____ degree or certificate obtained

____ the duration of the course

____ the year you finished it

Work experience as a midwife

The next section asks some questions regarding your experience as a midwife following your training. Before we begin, please listen to the following definition of a midwife.

1. A midwife is generally considered to be a person who can give the necessary supervision, care, and advice to women during pregnancy, labour, and the postpartum period. She is able to conduct deliveries on her own responsibility and to care for the newborn and infant. Additional responsibilities include health counselling and education.

Accepting this as an accurate definition, have you practiced as a midwife following completion of your training?

____ no ____ yes

(IF THE RESPONDENT ANSWERS NO, SKIP TO THE NEXT SECTION, PAGE 8, THE WILLINGNESS TO RETRAIN SECTION.)

(IF THE RESPONDENT ANSWERS YES:) Please tell me the country or countries where you practiced, with dates. **(IF THE RESPONDENT HAS PRACTICED IN CANADA, RECORD THE PROVINCE OR TERRITORY WHERE SHE PRACTICED.)**

__________ country ____ year started ____ year stopped

__________ country ____ year started ____ year stopped

__________ country ____ year started ____ year stopped

2. Since completing your midwifery training, how many clients have you followed through the entire pregnancy cycle (during pregnancy, labour, and in the postpartum period)?

____ clients

3. Approximately how many babies have you delivered since your midwifery training? **(SOME MIDWIVES MAY OBJECT TO THE WORD "DELIVERY" BECAUSE OF THE MEDICAL CONNOTATION. EXPLAIN THAT WE ARE USING THIS WORD BECAUSE WE COULD NOT COME UP WITH A MORE SATISFACTORY ALTERNATIVE WORD.)**

____ deliveries

4. I am going to read a number of places where babies might be born. After I read each phrase, please tell me how many babies you have delivered there since completing you midwifery training.

____ hospital

____ clinic

____ birthing center

____ home

____ other

5. Are you currently practicing midwifery or have you practiced midwifery in Ontario in the past year?

____ yes

____ no **(IF THE RESPONDENT ANSWERS NO SKIP TO THE NEXT SECTION, PAGE 8, WILLINGNESS TO RETRAIN.)**

6. In your Ontario practice, how many clients do you *typically* see through the entire pregnancy cycle in a year? In other words what is your typical annual client load?

____ clients

7. In your Ontario practice, how many babies do you typically deliver in a year?

____ deliveries

8. How many of these deliveries occurred in a ...

____ hospital

____ clinic

____ birthing center

____ home

____ other

9. I am going to read some of the major functions of a midwife. Please indicate what percentage of your time you spend performing each of these functions in your Ontario practice?

____ pregnancy care (individual attention to clients)

____ prenatal classes

____ labor care (excluding delivery)

____ labor care (including delivery)

____ care for the new mother

____ care for newborn and infant

____ family planning

____ health counselling and education

10. In what location do you currently practice? **(IF THE PRACTICE IS RURAL OR IN AN EXTREMELY REMOTE REGION, OBTAIN THE NAME OF THE CLOSEST TOWN.)**

____

11. I am going to read a number of phrases indicating various types of midwifery practices. Please tell me which phrase best describes your Ontario practice?

____ independent or private practice with other midwives (group practice)

____ independent practice by yourself (solo practice)

____ independent practice with family practitioner

____ independent practice with an obstetrician

____ practicing with a physician in a doctor's office as an employee

____ practicing in a birthing center as an employee

____ practicing in a clinic or community health facility as an employee

____ working scheduled shifts as an employee

12. Which phrase best describes your current arrangement with your physician for home births?

____ co-operative, provides pre-natal care only

____ co-operative, provides hospital liaison and emergency care

____ uncooperative

____ no arrangement with a physician

____ other (Please specify) ____________________

Willingness to retrain and practice as a midwife

Now I'd like to ask you some questions about whether you want to practice midwifery in Ontario when it is legalized.

1. When the practice of midwifery is legalized in Ontario, do you plan to practice as a midwife?

____ certainly will ____ probably will ____ uncertain

____ probably will not ____ certainly will not

2. When midwifery is legalized in Ontario, how important are the following factors in influencing your decision to practice as a midwife?

a. The length of a qualifying course

____ very important ____ somewhat important

____ not important ____ not at all important

____ undecided

b. The cost of a qualifying course

____ very important ____ somewhat important

____ not important ____ not at all important

____ undecided

c. Distance of a qualifying course from where you live

____ very important ____ somewhat important

____ not important ____ not at all important

____ undecided

d. The pre-requisite requirements for taking the qualifying course

_____ very important _____ somewhat important

_____ not important _____ not at all important

_____ undecided

e. Other (please specify).

1.

2.

3.

4.

3. In order to practice as a qualified midwife would you be willing to take a course lasting

4 months? _______ yes _______ no _______ unsure

8 months? _______ yes _______ no _______ unsure

16 months? _______ yes _______ no _______ unsure

Midwifery practice preferences

1. Now I am going to read a number of statements regarding midwifery and its implementation in Ontario. After I read each statement, please indicate whether you agree with the statement, strongly agree with it, disagree, or strongly disagree with it, or have no opinion.

a. I believe midwifery should be recognized as an independent profession with separate educational programs and its own regulatory agency.

_____ strongly agree _____ somewhat agree

_____ no opinion _____ disagree

_____ strongly disagree

b. I believe midwifery should be a nursing specialty requiring specialized preparation following basic nursing education.

_____ strongly agree _____ somewhat agree

_____ no opinion _____ disagree

_____ strongly disagree

c. I believe qualified midwives who are not nurses should be allowed to practice in Ontario.

_____ strongly agree _____ somewhat agree

_____ no opinion _____ disagree

_____ strongly disagree

d. I believe qualified midwives who are not nurses should be allowed to deliver babies in hospitals.

_____ strongly agree _____ somewhat agree

_____ no opinion _____ disagree

_____ strongly disagree

e. I believe any qualified midwife should be permitted to conduct home births.

_____ strongly agree _____ somewhat agree

_____ no opinion _____ disagree

_____ strongly disagree

f. I believe that parents have the right to decide where their children will be born.

_____ strongly agree _____ somewhat agree

_____ no opinion _____ disagree

_____ strongly disagree

g. I believe that parents have the right to decide who will assist them in the delivery of their child.

_____ strongly agree _____ somewhat agree

_____ no opinion _____ disagree

_____ strongly disagree

2. Here are some different options for the practice of midwifery. After I read each option, please indicate whether you *personally* favor or strongly favor the option, oppose or strongly oppose it, or are undecided. Are you in favor of conducting your practice...

a. In a group practice with individual midwives assigned to individual clients

_____ strongly in favor _____ somewhat in favor

_____ undecided

_____ opposed _____ strongly opposed

b. As a group practice where a group of midwives has responsibility for a group of clients, but individual midwives are not assigned to individual clients

_____ strongly in favor _____ somewhat in favor

_____ undecided

_____ opposed _____ strongly opposed

c. As an independent practice by yourself (solo practice)

_____ strongly in favor _____ somewhat in favor

_____ undecided

_____ opposed _____ strongly opposed

d. As an independent practice with a family practitioner

____ strongly in favor ____ somewhat in favor

____ undecided

____ opposed ____ strongly opposed

e. As an independent practice with an obstetrician

____ strongly in favor ____ somewhat in favor

____ undecided

____ opposed ____ strongly opposed

f. Practicing with a physician in a doctor's office as an employee

____ strongly in favor ____ somewhat in favor

____ undecided

____ opposed ____ strongly opposed

g. Practicing in a birthing center as an employee

____ strongly in favor ____ somewhat in favor

____ undecided

____ opposed ____ strongly opposed

h. Practicing in a clinic or community health facility as an employee

____ strongly in favor ____ somewhat in favor

____ undecided

____ opposed ____ strongly opposed

i. Working scheduled shifts as an employee in a hospital

____ strongly in favor ____ somewhat in favor

____ undecided

____ opposed ____ strongly opposed

3. If you were interested in one of the independent or private practice options, how many clients do you think you would want to manage per year?

____ not interested in the independent practice option

____ less than 25 cases per year

____ 25 to 49 cases per year

____ 50 to 99 cases per year

____ more than 100 cases per year

____ don't know

4. I am going to read a number of different methods by which midwives could be paid. After I read each option please indicate whether you favor or strongly favor the option, oppose or strongly oppose it, or are undecided.

a. salary

____ strongly in favor ____ somewhat in favor

____ undecided

____ opposed ____ strongly opposed

b. fee for service paid directly by clients

____ strongly in favor ____ somewhat in favor

____ undecided

____ opposed ____ strongly opposed

c. fee for service covered by OHIP

____ strongly in favor ____ somewhat in favor

____ undecided

____ opposed ____ strongly opposed

5. When midwifery is legalized in Ontario where would you want to practice midwifery? **(IF A REMOTE REGION IS MENTIONED, GET THE NAME OF A NEARBY TOWN.)**

________________________ town ____ unsure

____ don't plan to practice

6. What do you consider the basic appropriate educational preparation for a beginning (entry level) midwife? You can check more than one response.

____ diploma program offered by a college of applied arts and technology

____ baccalaureate degree offered by a university or Ryerson Polytechnical Institute

____ masters degree offered by a university

____ formal apprenticeship program

____ other (please specify) ________________

7. How long do you think it should take to complete a program for a beginning (entry level) midwife?

____ years

8. I am going to read a number of procedures. Please indicate whether you believe midwives should be trained and permitted to perform them?

Use a vacuum extractor? ____ Yes____ No

Use forceps? ____ Yes____ No

Perform an episiotomy? ____ Yes____ No

Repair episiotomy or skin laceration? ____ Yes____ No

Conduct initial assessment of a newborn? _____ Yes_____ No

Intubate a newborn? _____ Yes_____ No

Perform an amniotomy? _____ Yes_____ No

Administer local anesthesia? _____ Yes_____ No

Prescribe common medications? _____ Yes_____ No

Order common diagnostic procedures?_____ Yes_____ No

Biographical information

To conclude, I would like to ask you a few background questions.

1. Sex: _____ male _____ female

2. In what year were you born? __________

3. I am going to read a number of degrees obtained from educational institutions. Please indicate after I read the degree whether or not you have it.

   _____ high school certificate

   _____ BA/BSc

   _____ BScN

   _____ RNA

   _____ RN

   _____ MA/MSc

Are there any other degrees or certificates you have which I have not mentioned?

____

____

4. Where do you currently live? ____________________

5. What is your current marital status?

   _____ single _____ separated _____ widowed

   _____ married _____ divorced _____ other

6. Are you the primary caretaker for any children?

   _____ no _____ yes

   How many children do you have under 18 years in age?

   _____ children

7. Are you currently employed?_____ no _____ yes

   (IF YES) Please briefly describe your job?

   ____

   ____

8. In what range was your annual income last year?

   _____ less than $10,000

   _____ between $10,000 and $20,000

   _____ between $20,000 and $30,000

   _____ between $30,000 and $40,000

   _____ more than $40,000

Thank you very much for your time and cooperation. For this survey to be successful we would like to interview a total of 260 midwives. If you know any practicing or non-practicing midwives living in Ontario, we would appreciate if you could tell us their names, addresses and phone numbers so we can include them in our survey.

Name	Address	Phone number
1.		
2.		
3.		
4.		
5.		

Thanks again for your help. If you think of anyone else, please phone us or have them call us collect at (416) 532-7371.

MIDWIFERY STUDY:

REPORT OF THE 1986 SURVEY OF CNO REGISTRANTS

JUNE 1987

APPENDIX 3 (PART 2)

ACKNOWLEDGEMENTS

This survey was co-sponsored by the College of Nurses of Ontario and the Ontario Government Task Force on the Implementation of Midwifery in Ontario. The College gratefully acknowledges the interest and financial commitment of the Task Force and the Ministry of Health. In addition, the assistance of Task Force member Karyn Kaufman, RN, DrPH, is sincerely appreciated.

The report was prepared by Kathleen M. Clark, RN, Coordinator—Monitoring and Evaluation, with the support of Dianne Patychuk, RN, Research Assistant.

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SUMMARY OF REPORT

INTRODUCTION

This is the report of a study co-sponsored by the College of Nurses of Ontario and the Task Force on the Implementation of Midwifery in Ontario. The study was a follow-up to a CNO survey of its registrants conducted in the fall of 1985.

PURPOSES

The study was designed in response to the need for more specific information concerning the midwifery background of Registered Nurses (RNs) and Registered Nursing Assistants (RNAs) and to meet the following objectives:

1. To identify the previous midwifery education and practice experience of RNs and RNAs in Ontario.
2. To identify the midwifery practice preferences of the RNs and RNAs who responded to the 1985 CNO registrant survey.
3. To evaluate the accuracy of the rate of response to the 1985 CNO registrant survey.

METHODOLOGY

The study involved two surveys. A questionnaire was mailed to 942 of the respondents to the 1985 survey to gather specific information concerning their midwifery preparation, work experience, and practice preferences (Survey I). In the second survey (Survey II), the midwifery information slip used in the 1985 survey was sent to a randomly selected stratified sample of 2093 registrants to obtain data which would provide an estimate of the number of 1986 registrants with midwifery preparation.

FINDINGS

The total rate of response to Survey I was 79.4%, and an 80.3% return rate was achieved in Survey II. The proportion of Survey II respondents who reported midwifery preparation was significantly higher than that found in the 1985 survey (4.0%). Depending upon the assumptions made about the proportion of non-respondents to Survey II who had midwifery preparation, the proportion of 1986 registrants with midwifery preparation could vary from 6.1% to 7.3% or more.

Midwifery Preparation

These findings, and those pertaining to regulation, work experience, and practice preferences, are results obtained from Survey I. Readers are directed to page 335 for a discussion of the design of this survey and page 338 for an explanation of the data analysis procedures. The responses of the sampled RN nurse-midwife subgroup were weighted by a factor of 15; hence the reporting of over 4500 respondents to Survey I when, as stated above, only 942 were actually surveyed.

4025 respondents (89.2%) had successfully completed a midwifery education program; it was therefore estimated that between 6000 and 7300 of the 1986 CNO registrants have had some form of midwifery preparation.

Although many RNs and RNAs have had midwifery training, over 80% acquired it before 1970. Only six RN respondents have completed a program of midwifery since 1980, and 329 (8.2%) have taken a midwifery refresher course. The following are the dominant characteristics of the respondents' midwifery preparation: 75.7% trained as midwives in the United Kingdom; 84.2% of the RNs took programs 6 to 12 months long; 73.5% of the RNAs took programs 12 to 24 months in length; most of the respondents took programs sponsored by hospitals; they typically were awarded a certificate upon completion of the program; and all of the programs combined clinical experience with classroom teaching.[a]

Midwifery Regulation

Certification was the most common regulatory credential received by the respondents (49.3%).[a]

Midwifery Experience

Just over half of the respondents (2308, 51.1%) had practised midwifery; therefore, between 3400 and 4200 of the 1986 CNO registrants were estimated to have had some midwifery experience.

852 of the total respondents (18.8%) had worked as maternal/infant nurses and public health nurses but not as midwives.

The amount of midwifery experience of the respondents was limited and very little of it was recent; 72.8% (1680) had less than five years of practice as midwives and only 49 (2.1%) had practised within the past five years.

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[a] See pp. 331-2 for a chart which summarizes a comparison of the characteristics of the total group of respondents with the group of respondents who reported they want to practise midwifery in Ontario.

CHART SUMMARY OF THE EDUCATION AND PRACTICE PROFILE OF SURVEY I RESPONDENTS

EDUCATION AND PRACTICE CHARACTERISTICS	TOTAL RESPONDENTS RNs AND RNAs	RN AND RNA RESPONDENTS WHO REPORTED AN INTEREST IN PRACTISING MIDWIFERY
MIDWIFERY EDUCATION	(n#4514)[1]	(n#621)[2]
Successful completion of a midwifery education program	89.5% (4025) reported having successfully completed a midwifery education program.	91.3% (567) reported having successfully completed a midwifery education program.
	(n#4025)[3]	(n#567)[4]
Location of midwifery preparation	75.7% obtained their midwifery education in the United Kingdom.	61.2% obtained their midwifery education in the United Kingdom.
Length of midwifery program	84.2% (3278) of RNs completed programs 6 to 12 months long; 73.5% (97) of RNAs completed programs 12 to 24 months long.	79.0% (403) of RNs completed programs 6 to 12 months long; 73.7% (42) of RNAs completed programs 12 to 24 months long.
Year program completed	80.8% were educated as midwives before 1970; only .1% have completed a program since 1980.	80.6% were educated as midwives before 1970; .4% have completed a program since 1980.
Educational credential	79.6% received certificates upon completion of their program; .3% received a baccalaureate degree.	65.1% received certificates upon completion of their program; .5% received a baccalaureate degree.
Program sponsor	79.9% took programs sponsored by hospitals; 10.7% attended independent schools of midwifery.	51.1% took programs sponsored by hospitals; 32.3% attended independent schools of midwifery.
Type of program	All programs combined theory and clinical practice.	All programs combined theory and clinical practice.
Refresher course	8.2% have taken a refresher course.	1.6% have taken a refresher course.
REGULATION	(n#4025)[3]	(n#567)[4]
Regulatory credential	49.3% were certified to practise midwifery; 27.3% were registered; 8.4% were licensed.	34.2% were certified to practise midwifery; 46.0% were registered; 15.9% were licensed.

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[1], [2], [3], [4] See pages 339, 362, 366

CHART SUMMARY OF THE EDUCATION AND PRACTICE PROFILE OF SURVEY I RESPONDENTS

EDUCATION AND PRACTICE CHARACTERISTICS	TOTAL RESPONDENTS RNs AND RNAs	RN AND RNA RESPONDENTS WHO REPORTED AN INTEREST IN PRACTISING MIDWIFERY
MIDWIFERY PRACTICE	(n#4514)[5]	(n#621)[6]
Practised midwifery as defined	51.1% (2308) reported having practised as a midwife.	17.7% (110) reported having practised as a midwife.
	(n#2308)[7]	(n#110)[8]
Total number of years of midwifery practice	72.8% have less than five years midwifery practice experience.	64.6% have less than five years midwifery practice experience.
Recency of midwifery practice	.6% reported practising as a midwife in 1986; 2.1% have worked as midwives within the past five years.	1.8% reported practising as a midwife in 1986; 11.8% have worked as midwives within the past five years.
Midwifery functions	All functions, except family planning, were performed by more than half of the total respondents.	The respondents in this group did not provide intrapartum care, excluding deliveries, or postpartum care as much as the total respondents; otherwise, the group performed all other midwifery functions more than the total respondents.
Practice settings	91.8% practised in hospitals; 59.5% have conducted home births; 10.1% worked in outpost health services; 4.4% worked in birthing centres; 2.1% reported private midwifery practices.	67.6% practised in hospitals; 71.3% have conducted home births; 27.8% worked in outpost health services; 12.0% worked in birthing centres; 26.9% reported private midwifery practices.
Location of previous midwifery practice	61.1% have practised in the United Kingdom; 11.9% have practised midwifery in Canada; 7.4% practised in the West Indies; 3.1% worked as midwives in the Philippines.	26.3% have practised in the United Kingdom; 17.3% have practised midwifery in Canada; 12.2% practised in the West Indies; 25.5% worked as midwives in the Philippines.

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[5], [6], [7], [8] See pages 339, 362, 372, 377

CHART SUMMARY OF THE EDUCATION AND PRACTICE PROFILE OF SURVEY I RESPONDENTS

FOOTNOTES

[1] The total number of RN and RNA respondents (n#4514) was used to calculate the percentage of respondents who reported having successfully completed a midwifery education program.

[2] The number of RN and RNA respondents who want to practise midwifery (n#621) was used to calculate the percentage of this subgroup who also reported having sucessfully completed a midwifery education program.

[3] The responses of the RN and RNA respondents who successfully completed a program (n#4025) were then analyzed to determine the characteristics of their midwifery preparation. The following percentages were calculated in terms of the group size n#4025.

[4] The responses of the RNs and RNAs who want to practise midwifery and have completed a program (n#567) were then analyzed to determine the educational characteristics of this particular group of respondents. The number of respondents in the group (n#567) provided the base for the following percentages.

[5] The total number of RN and RNA respondents (n#4514) was used to calculate the percentage of respondents who reported having practised as a midwife.

[6] The number of RN and RNA respondents who want to practise midwifery (n#621) was used to calculate the percentage of this subgroup who also reported having practised as a midwife.

[7] The responses of the RNs and RNAs who reported having practised midwifery as defined (n#2308) were then analyzed to determine the characteristics of their midwifery practice. The following percentages were calculated using the group size n#2308.

[8] The responses of the RNs and RNAs who want to practise midwifery and have previously worked as midwives (n#110) were also analyzed to determine the practice characteristics of this particular group of respondents. The number of respondents in the group (n#110) provided the base for the following percentages.

The following are the dominant characteristics of the respondents' midwifery experience: 1410 (61.1%) had practised as midwives in the United Kingdom, 275 (11.9%) had been midwives in Canada; over 90% (2119, 91.8%) had worked as midwives in hospitals and 1374 had conducted home births (59.5%); seven of the eight midwifery functions had been performed by more than half of the respondents (family planning was the exception where only 38.3% (835) of the RNs had experience[b]); postpartum, antepartum, and intrapartum care were the functions performed most by the respondents; 2047 (88.7%) reported having provided intrapartum care including deliveries and 1757 (76.1%) had given intrapartum care that did not involve actually delivering the infant.[a]

Midwifery Practice Preferences

Only 621 respondents (13.7%) expressed definite interest in practising as midwives when it becomes legal in Ontario to do so; it was estimated that between 900 and 1200 of the 1986 CNO registrants with previous midwifery preparation would want to practise midwifery. A total of 1564 (34.7%) responded "maybe/depends" or "don't know," and 1949 (43.2%) were not interested.

Seventy-nine percent (490) of the RNs and RNAs who want to practise midwifery strongly agreed with the statement that midwifery should be a nursing specialty requiring specialized preparation following basic nursing education; 53.6% (333) also strongly agreed that midwifery should be recognized as an independent profession. Forty-three (265) percent agreed that qualified midwives who are not nurses should be allowed to practise in Ontario; 41.3% (258) agreed that qualified midwives who are not nurses should be allowed to deliver babies in hospitals. Sixty-one percent (379) of those who want to practise midwifery strongly agreed that any qualified midwife should be permitted to conduct home births.

The RNs who want to practise midwifery expressed a preference for independent/private practice with physicians; the RNAs favoured practice options in which they could work as employees. Solo practice was the option least favoured by both categories. 181 (29.2%) respondents who want to resume their midwifery careers and establish independent practices said they would manage more than 100 clients per year; 175 of these were RNs.

Most of the registrants (455, 73.3%) who want to practise midwifery indicated a willingness to take a refresher course; none said no. Cost, accessibility, scheduling, and length of these courses are some of the factors which will influence registrants' enrollment decisions.

Many respondents did not answer the questions concerning methods of payment; 418 (67.3%) of those who did favoured salaries; 249 (40.1%) were interested in fee-for-service covered by OHIP.

Respondents who want to practise midwifery identified post-basic certificate programs as the appropriate type of program for beginning midwives with nursing backgrounds; 36.8% (201) of the RNs favoured university/Ryerson sponsored programs; 34.1% (186) of the RNs chose C.A.A.T. sponsored programs; the majority of RNAs (47, 62.7%) chose programs offered in the C.A.A.T.s; however, 37.3% (28) of the RNAs also identified programs sponsored by Ryerson or a university as being appropriate. Only 33 respondents (5.3%) preferred post-RN baccalaureateprograms. A diploma program offered by a C.A.A.T. was the model of basic preparation considered by 32.2% (200) as appropriate for non-nurses; 16.9% (105) chose a baccalaureate degree program from a university or Ryerson.

A majority of both RN and RNA respondents supported the training of midwives to carry out the following procedures: perform episiotomy, conduct initial assessment of the newborn, order common diagnostic procedures, repair episiotomy or skin lacerations, administer local anesthetic, and prescribe common medications. They did not support the use of vacuum extractors, forceps, intubating the newborn, and performing amniotomy.

CONCLUSIONS

Although the number of RNs and RNAs with midwifery preparation and work experience appears large, relatively few have taken midwifery courses since 1980 or worked as midwives within the past five years. The registrants interested in resuming their careers as qualified midwives recognize their need to take refresher programs. The registrants who want to practise midwifery once it is legal to do so consider midwifery a nursing specialty but believe it should be regulated as an independent profession. They also support qualified midwives being permitted to conduct home births. These views differ from the positions of the College of Nurses.

Traditional models of nursing preparation were chosen as appropriate to educate nurses and non-nurses as midwives. The cost and accessibility barriers to participation in other programs of continuing nursing education were also identified as deterrents to enrollment in midwifery programs.

While RNAs expressed their preferences for practice options in which they would function as employees, RNs favoured independent or private practice with physicians. Registrants in neither category expressed much interest in establishing solo practices.

Following the completion of this Report, the demographic characteristics of the respondents to both Survey 1 and Survey 2 were analysed and tabulated. Those interested in this information may obtain from the College of Nurses of Ontario a copy of the Midwifery Study: Supplementary Report of the Demographic Characteristics of Survey 1 and Survey 2 Respondents, July, 1987.6

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[a] See pp. 331-2 for a chart which summarizes a comparison of the characteristics of the total group of respondents with the group of respondents who reported they want to practise midwifery in Ontario.

[b] Eighty RNAs (63.5%) reported having provided family planning services as part of their midwifery experience.

INTRODUCTION

Midwifery is a priority policy issue in Ontario and information concerning the supply of and demand for midwives is needed by those developing public and professional policies pertaining to midwifery education, practice, and regulation. Given that midwifery has not been legalized in Ontario, or anywhere else in Canada, such information has not been systematically gathered nor is it readily available. One source of information regarding the potential supply of midwives exists in the registrant body of the College of Nurses of Ontario (CNO). Among the registrants of the College there are Registered Nurses (RNs) and Registered Nursing Assistants (RNAs) who have had midwifery preparation and who have practised as midwives in other countries. It has been assumed that these registrants will constitute a likely source of nurse-midwives when the practice of midwifery is legally introduced into the Ontario health care system.

Little is known about the midwifery education and work experience of RNs and RNAs in Ontario. Registrants with midwifery backgrounds have not been asked whether they want to resume their midwifery practice when it becomes legal to do so. Recognizing the need for much improved information about the midwifery preparation, work experience, and career preferences of RNs and RNAs in the province, the College of Nurses and the Task Force on the Implementation of Midwifery in Ontario co-sponsored a survey of CNO registrants. This is the report of the study conducted from June 1986 to June 1987.

BACKGROUND INFORMATION

In 1985, the College of Nurses carried out a study of midwifery and associated issues (Clark, 1986). The College anticipated its future involvement in the formulation of public and professional policies regarding midwifery and identified the need for information which would contribute to CNO Council's policy decision-making. The study included a review of pertinent literature and three surveys, one of which was a survey of CNO registrants to determine the number of RNs and RNAs who were, or previously had been, midwives.[1] The survey produced a beginning, but limited, database. Respondents were asked to identify themselves so as to enable follow-up studies in the future.

In January 1986, the Provincial Government established the Task Force on the Implementation of Midwifery in Ontario. The Task Force was created to examine and make policy recommendations in relation to the education of midwives, requirements for entry to practice, scope and standards of practice, governance, location of practice, and patient access.

When the report of the CNO study of midwifery was accepted by the College Council and approved for distribution, it was shared with members of the Task Force who expressed interest in the results of the registrant survey. Discussions involving CNO staff and Task Force members led to a decision to co-sponsor a follow-up study to be conducted by the College of Nurses.

PURPOSES

A total of 5409 registrants responded to the initial 1985 survey indicating whether they were or had been midwives, and whether they had acquired formal midwifery preparation before or after their nursing education. Because the survey was carried out by inserting a reply slip in the renewal package sent out to approximately 136,000 CNO registrants as part of the annual registration process, it was not possible to ask more detailed questions at the time. Nor was it feasible to request and analyze replies from all the registrants. Only RNs and RNAs with previous midwifery preparation were asked to return the slip. In addition, the absence of a definition of midwifery left the respondents free to interpret the meaning of the term and decide whether they should respond to the survey. As a consequence of these design limitations it is not known how many registrants with midwifery preparation did not return an information slip and should have; nor can it be determined how many registrants responded to the questionnaire who should not have.[2]

The follow-up study of CNO registrants was planned to respond to the need for more specific information concerning the midwifery backgrounds of RNs and RNAs and to meet the following objectives:

1. To identify the previous midwifery education and practice experience of Registered Nurses (RNs) and Registered Nursing Assistants (RNAs) in Ontario.
2. To identify the midwifery practice preferences of the RNs and RNAs who responded to the 1985 CNO registrant survey.
3. To evaluate the accuracy of the rate of response to the 1985 CNO registrant survey.

METHODOLOGY

The study involved surveying two groups of College registrants. Because of the size of the groups and the limited time available for data collection, it was necessary to use mailed questionnaires to gather the desired information. To facilitate the discussion of the study methodology and the report of findings, the surveys of the two groups will be referred to as Survey I and Survey II.

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[1] See Appendix A for the report of the registrant survey as presented in *Midwifery—A CNO Policy Background Paper*, 1986.

[2] Comments volunteered by some respondents suggested they were not midwives but had in the past assumed some or all of the responsibilities of a midwife, e.g. RNs and RNAs who had practised maternal/child nursing or registrants with public health experience.

Registrant Groups and Sampling Procedures

Survey I involved the RNs and RNAs who responded to the 1985 CNO registrant survey. The respondents were classified into six subgroups according to their registrant category (RN or RNA) and their midwifery preparation (before nursing education, after nursing education, and other) (Table 1). Since five of the subgroups were relatively small, all respondents in these groups were included in the follow-up survey. However, the RNs who acquired their formal midwifery preparation following their nursing education comprised a large category of respondents. Rather than send questionnaires to all of the respondents in this category, a sample of 320 was randomly drawn.[3]

TABLE 1. RESPONSES TO CNO REGISTRANT SURVEY, 1985

TYPE OF MIDWIFERY	RN		RNA		TOTAL	
PREPARATION	NO.	%	NO.	%	NO.	%
Acquired formal midwifery education *after* nursing education	4763	92.2	103	42.6	4866	90.0
Acquired formal midwifery education *before* nursing education	85	1.6	102	42.1	187	3.4
Other	319	6.2	37	15.3	356	6.6
TOTAL	5167	100.0	242	100.0	5409	100.0

Survey II was designed to assess the accuracy of the rate of response to the 1985 registrant survey. A revised reply slip was mailed to a randomly selected stratified sample of 1570 RNs and 523 RNAs drawn from the total registrant body of the College of Nurses.[4]

Development and Pretesting of the Questionnaires

The data collection instrument for Survey I was developed by the CNO Coordinator of Monitoring and Evaluation in consultation with Karyn Kaufman, RN, DrPH, a member of the Task Force.[5] Dr. Kaufman contributed clinical expertise to the drafting of the questionnaire and provided input regarding the information needs of the Task Force.

Items designed to gather data about the previous midwifery education and practice experience of the RNs and RNAs were included in the questionnaire along with questions on the registrants' preferences regarding selected midwifery policy issues. The section pertaining to work experience in maternity care was introduced by a definition of a midwife.[6] This definition was based on preliminary thinking of the CNO Task Force on the Regulation of Midwifery and suggestions from K. Kaufman. Respondents were directed to use the definition when responding to the questions concerning their practice as a midwife.

A panel of registrants was used to pretest the questionnaire for clarity, face validity, and ease of response. The panel included four members of the CNO's Task Force on the Regulation of Midwifery and five staff members employed in the obstetrical nursing services at the McMaster Division of Chedoke-McMaster Hospital, Hamilton, Ontario. In addition to the pretest of the instrument provided by the panel, the questionnaire was also subjected to an objective, external assessment requested by the Task Force and conducted by Environics Research Group Ltd. The CNO questionnaire was evaluated at the same time as another questionnaire developed by Norpark Computer Design, Inc. for use in a separate midwifery survey commissioned by the Task Force. Some revisions were made in the questionnaire based on results of the pretest and feedback from the external assessment.

Because Survey II was being carried out to assess the accuracy of the results of the initial CNO registrant survey it was necessary to use essentially the same information slip.[7] The only change introduced to the slip was the addition of a response option for those registrants who had not taken any midwifery courses or programs and, therefore, were not, nor had been, midwives. This revision was necessitated by the fact that in this survey each registrant who received a letter and slip was asked to respond, not just those with midwifery preparation.

The questionnaires and information slips were mailed the third week of July. Prepaid return envelopes were provided to encourage an adequate response rate. Thank you letters were sent to respondents and reminder letters were mailed at four and six week intervals.[8] Arrangements were made to have the data computer analyzed at the Ontario Physician Manpower Data Centre using the SPSS[9] statistical software package.

FINDINGS

Response Rates

The overall rate of response to Survey I was 79.4%, slightly less than the desired 80% (Table 2). With four of the subgroups, the actual rate of return was close to, or more than, the desired rate. The response rates from two of the RNA groups were sufficiently less than 80% so that caution needs to be exercised when considering registrant estimates based on findings from these two groups.

The goal of an 80% response rate was achieved in Survey II. Completed and useable responses were received from 1258 RNs for a rate of return of 80.1%; and 80.7% (422) of the RNAs returned their midwifery information slips. (Table 3).

TABLE 2. RATE OF RETURN TO SURVEY I

Group	Number of Questionnaires Sent[1]	Number of Useable Responses	Rate of Return %
1. RN Nurse—midwives	320[3]	269	84.1
2. RN Direct entry	87	72	82.8
3. RN Other	306	239	78.1
4. RNA Nurse—midwives	93	74	79.6
5. RNA Direct entry	108	77	71.3
6. RNA Other	28	17	60.7
Total	942	748	79.4

[1] In order to select the sample for Group 1 (RN nurse-midwives) and prepare the mailing lists, the responses to the 1985 midwifery survey were recounted revealing errors in the 1985 counts. The corrected number of respondents is reported here and has been used in the calculation of the rates of return as well as subsequent analyses.

[2] The rates of return were calculated using the number of completed and useable responses. There were 17 blank or incomplete questionnaires also returned. No attempt was made to contact the non-respondents, 15 of whom had moved and therefore did not receive their questionnaires.

[3] The sample size for Group 1 was calculated on the basis of n#4763; the actual sample was drawn from the corrected sampling frame of 4812.

TABLE 3. RATE OF RETURN TO SURVEY II

Group	Number of Slips Sent	Number of Useable Responses	Rate of Return %
RNs	1570	1258	80.1
RNAs	523	422	80.7
Total	2093	1680	80.3

[1] The rates of return were calculated using the number of completed and useable slips. Three returns had to be discarded and 30 registrants did not receive their slips because they had moved.

Survey II Compared with 1985 Survey Results

The purpose of Survey II was to obtain an estimate of the number of CNO registrants with midwifery preparation to compare with the findings of the previous survey conducted in 1985 (Figure 1). Although only 127 of the 1,680 respondents reported having midwifery preparation (Table 4), the proportion of respondents with midwifery education was higher than in the 1985 survey in which the number of respondents represented 4.0% of the registrant body at that time.[9] Assuming that none of the non-respondents had midwifery preparation, the proportion of respondents with midwifery education was calculated to be 6.1%.[10] This produces the minimum proportion possible. An alternative assumption is that the non-respondent group contained registrants with midwifery preparation in the same proportion as the respondent group, then the proportion of registrants with midwifery preparation would be 7.3%.[11] A more extreme and unlikely assumption is that all the non-respondents had midwifery preparation. Based on this assumption, the calculated proportion of registrants with midwifery preparation would be 25.8%.[12]

These findings indicate that the results of the 1985 survey underestimated the number of registrants with midwifery preparation. The difference between the two independent proportions (.040 and .061) was statistically significant ($Z = 4.8, p = 0.01$). Given that the total number of CNO registrants was 134,627 on July 3, 1986, when the sample for Survey II was drawn, a conservative estimate of the number of registrants with midwifery preparation is 8,212 (6.1% of 134,627).[13]

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[3] The sample size was decided in consultation with Dr. Paul Corey and Gustavo Arraiz of the Clinical Research Support Unit, Department of Preventative Medicine and Biostatistics, University of Toronto. They recommended a sample of 256 so that the 90% confidence interval about any calculation of a proportion would not exceed ten percentage points (ie. 5%). Assuming an 80% response rate it was determined that a sample size of 320 would produce the necessary number of respondents.

[4] The sample size for Survey II was also determined in consultation with Dr. Paul Corey and Gustavo Arraiz. It was based upon the total number of RN and RNA registrants as of July 3, 1986 (101,540 RNs and 33,087 RNAs). The proportion of RNs and RNAs with midwifery experience according to the findings of the 1985 survey was found to be 4%. The sample size for Survey II was set at a level to detect a difference of 2% as a statistically significant difference (at a significance level of 0.05 and power of 0.95) when comparing the proportion of registrants with midwifery preparation in the 1985 survey with the proportion found in the 1986 follow-up study. The final number of 1674 was adjusted in anticipation of an 80% response rate. The proportion of RNs and RNAs in the sample reflected the distribution of the two categories in the registrant population.

[5] Appendix B contains copies of the questionnaire and covering letter used in Survey I.

[6] For the purposes of this survey, a midwife was defined as a person who provides on her own responsibility antenatal, intrapartum, and postnatal care of essentially well mothers and infants, including health counselling and teaching.

[7] Appendix C includes the covering letter and information slip used in Survey II.

[8] Copies of these letters are available from the College of Nurses upon request.

[9] The proportion of 1985 respondents with midwifery preparation was calculated using the total number of CNO registrants as of October 23, 1985 and the corrected counts: 5,434/135,703 X 100 = 4.0%.

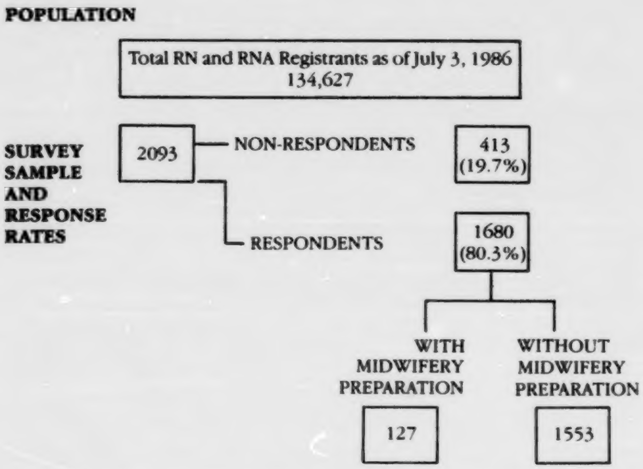
[10] The minimum proportion of 1986 respondents with midwifery preparation was calculated using the total sample size: 127/2,093 X 100 = 6.1%.

[11] The number of non-respondents was 2,093—1,680 = 413. If the number of non-respondents with midwifery preparation was in the same proportion as that found with the respondent group, the number would be 413/100 X 6.1 = 25. The proportion was then calculated as 127 ' 25/2, 093 X 100 = 7.3%.

[12] Assuming all the non-respondents (413) had midwifery preparation, the proportion would be 127 ' 413/2,093 X 100 = 25.8%.

[13] Using the proportions resulting from alternative assumptions, other estimates would be 9,828 (7.3% of 134,627) and 34,734 (25.8% of 134,627).

FIGURE 1. SURVEY II—POPULATION, SAMPLE, RESPONSE RATE, SELECTED ASSUMPTIONS AND THE ASSOCIATED REGISTRANT ESTIMATES.


POPULATION
Total RN and RNA Registrants as of July 3, 1986
134,627
SURVEY SAMPLE AND RESPONSE RATES
2093
NON-RESPONDENTS
413
(19.7%)
RESPONDENTS
1680
(80.3%)
WITH MIDWIFERY PREPARATION
WITHOUT MIDWIFERY PREPARATION
127
1553

Assumptions Used to Calculate Registrant Estimates

A. None of the non-respondents (n#413) had midwifery preparation; therefore, the minimum proportion of 1986 respondents with midwifery preparation was 127/2093 X 100 = 6.1% and the conservative estimate of the number of 1986 CNO registrants with midwifery preparation is 6.1% of 134,627 = 8,212.

B. The number of nonrespondents with midwifery preparation was in the same proportion as that found in the respondent group (ie. 6.1% of 413 = 25); therefore, based on this assumption the estimate of 1986 registrants with midwifery preparation is 7.3% of 134,627 = 9828 (7.3% = 127 + 25/2093 X 100).

C. All the non-respondents had midwifery preparation; therefore, based on this assumption, the unlikely estimate of 1986 registrants with midwifery preparation is 25.8% of 134,627 = 34,734 (25.8% = 127 + 413/2093 X 100).

TABLE 4. RESPONSES TO SURVEY II

TYPE OF MIDWIFERY PREPARATION	RN NO.	RN %	RNA NO.	RNA %	TOTAL NO.	TOTAL %
Acquired formal midwifery education *after* nursing education	80	6.4	3	0.7	83	4.9
Acquired formal midwifery education *before* nursing education	0	0.0	2	0.5	2	0.1
Other	39	3.1	3	0.7	42	2.5
Total respondents *with* midwifery preparation	119	9.5	8	1.9	127	7.5
Respondents *with no* midwifery preparation	1139	90.5	414	98.1	1553	92.5
Total respondents	1258	100.0	422	100.0	1680	100.0

Analysis of the Survey I Data

The questionnaire data were analyzed using the SPSS^x Crosstabs and Breakdown procedures. Group 1 (RN nurse-midwives) sample data were weighted by an inflation factor of 15[14] to permit the addition of the responses from the three RN subgroups and the reporting of results by RN and RNA categories (Figure 2). Given that the results of Survey II indicated that the number of respondents to the 1985 survey underestimated the actual number of CNO registrants with midwifery preparation, all the responses to Survey I were subsequently weighted by an additional inflation factor of 1.5[15] to provide estimates of the results in the total CNO registrant body. In Appendices D, E, F, G, and H, results are reported for both the respondents and the conservative registrant estimates.

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[14] The inflation factor was the number of respondents in Group 1 (4812) divided by the sample drawn from Group 1(320).

[15] This inflation factor was achieved by dividing the conservative estimate of 1986 CNO registrants with midwifery preparation (8212) by the corrected number of respondents to the 1985 survey (5434). An inflation factor of 1.8 resulted from calculations using the 7.3% proportion of registrants with midwifery preparation (ie. 9828/5434 = 1.8).

FIGURE 2. SURVEY I: POPULATION, SAMPLE, RESPONSE RATE, WEIGHTING.

	SUBGROUPS[1] NUMBER OF WEIGHTED RESPONDENTS[2] (WEIGHTING)	NUMBER OF RESPONSES TO 1985 SURVEY (POPULATION)	NUMBER OF QUESTIONNAIRES SENT IN 1986 SURVEY (SAMPLE)	NUMBER OF USEABLE RESPONSES TO 1986 SURVEY/ RATE OF RETURN (RESPONSE RATE)
1. RN NURSE - MIDWIVES	4812	320	269 84.1%	4035
2. RN DIRECT ENTRY	87	87	72 82.8%	72
3. RN OTHER	306	306	239 78.1%	239
4. RNA NURSE - MIDWIVES	93	93	74 79.6%	74
5. RNA DIRECT ENTRY	108	108	77 71.3%	77
6. RNA OTHER	28	28	17 60.7%	17
TOTAL	5434	942	748/79.4%	4514

1. The 1985 respondents assigned themselves to the subgroups.
2. The responses of subgroup 1 were weighted by a factor of 15. The responses of the other subgroup respondents were not weighted.

In addition to the analysis of the data by RN and RNA categories, the responses to the questionnaire by the six subgroups were also examined.[16] References to these analyses are made in the text of the report as appropriate.

The Midwifery Preparation of RNs and RNAs in Ontario

The educational background of RNs and RNAs with midwifery preparation relates directly to several policy issues. Decisions need to be made regarding the provision of basic and continuing education programs for midwives. Curriculum standards and guidelines will need to be set. The accessibility of midwifery programs relates, in part, to the volume and distribution of demand for midwifery services and qualified midwives. The demand for midwifery programs will also be generated by those seeking to qualify or requalify as midwives.

A considerable number of Survey I respondents (4025, 89.2%) reported having successfully completed a midwifery education program (Table Di).[17] Using the 1.5 and 1.8 inflation factors, it was estimated that between 6000 and 7300 of the 1986 CNO registrants had basic midwifery preparation. These estimates are less than those previously discussed in relation to Survey II (ie. 8212 and 9828) because the Survey I findings relate only to the respondents and estimated number of registrants who successfully completed a basic midwifery education program. The Survey II results provide the number of respondents and estimated registrants who had midwifery preparation, complete or incomplete, formal programs, apprenticeship programs or any other type of preparation defined by the respondents.

Even though the number of respondents with midwifery preparation appears large, it is imperative to note that only six RN respondents (.1%) completed their program after 1980 (Table Div). Seventeen percent of the respondents acquired their preparation between 1970 and 1979; but the basic education of the vast majority of the respondents (3249, 80.8%) preceded 1969, over 17 years ago. In addition, only 329 respondents (8.2%) said they had taken a midwifery refresher course (Table Dviii). Clearly, the midwifery knowledge and skill of these registrants is, for the most part, outdated and there is an obvious need for refresher courses as well as basic midwifery education programs. It could be argued that the midwifery training of many registrants is so out of date that a refresher program would be insufficient and completion of a basic program should be required for them to resume practice as qualified midwives.

The majority of respondents with midwifery preparation (92.8%) were RNs who acquired their midwifery education after their basic nursing education. Seventy-five percent of the respondents with midwifery preparation (3047, 75.7%) obtained their education in the United Kingdom (Table Dii). This finding is consistent with known patterns of immigration of nursing personnel to Ontario. Only 22 RNs reported training as midwives in Canada.[18] This is not surprising given the lack of explicit midwifery programs and the limited number of advanced nursing courses which include midwifery related knowledge and skills. None of the RNAs with midwifery preparation trained in Canada.

For most of the RN respondents (3278, 84.2%) their midwifery preparation was between six and twelve months duration (Table Diii). In contrast, the majority of the RNAs (97, 73.5%) completed programs which were 12 to 24 months long. Most of the RN and RNA respondents took programs that were sponsored by hospitals (3216, 79.9%) and recognized with certificates (3205, 79.6%) (Tables Dvi and Dv). The fact that so few (110, 2.7%) completed a university sponsored program explains, in part, the extremely low number of respondents with Bachelor's degrees (14, .3%) and the absence of any with Master's degrees in midwifery.

Contrary to the expectation that some registrants might have taken midwifery courses that consisted of classroom work only without any clincial experience, all the respondents who had completed a midwifery program said their courses combined the presentation of theoretical content with clinical experience (Table Dvii). In order to get some indication of the amount of clinical experience provided in the programs, the respondents were asked how many babies they were required to actually deliver for completion of their program. There was considerable variation in the responses which ranged from none to 98. The most frequent response was twenty deliveries (1029 respondents, 25.6%). The limits of the acceptable length of mailed questionnaires constrained further inquiry regarding the nature of midwifery education programs completed by CNO registrants.

Subsequent to the analysis of the midwifery preparation of the total number of respondents, the midwifery education of those who reported a desire to practise midwifery was specifically examined (Appendix E). Ninety-one percent (567) of the 621 respondents who said they wanted to practise as midwives had successfully completed a midwifery education program; this included 510 RNs and 57 RNAs (Table Ei). Twenty-three of the RNs (4.2%), all from the RN Other subgroup, reported having taken a course in advanced maternal and infant nursing. The estimated number of 1986 registrants who would want to practise midwifery and have successfully completed a midwifery program was between 800 and 1100 using the previously described inflation factors.

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[16] The six subgroups identified in the 1985 survey were: RN nurse-midwives, RN direct entry, RN other, RNA nurse-midwives, RNA direct entry, RNA other.

[17] The findings from Survey I have been reported only in terms of the RN and RNA categories (Appendices D, E, F, G, and H). Further analyses according to the six subgroups identified in the 1985 survey were carried out and are available from the College of Nurses of Ontario.

Once again, the proportion of respondents with recent midwifery preparation was small compared to the total group who reported an interest in resuming their midwifery practice. Eighty-one percent of the respondents (457, 80.6%) were educated as midwives before 1970 (Table Eiv). Two respondents from the RN Other subgroup reported completing a midwifery program between 1980 and 1986. Only 9 respondents (1.6%) had taken a midwifery refresher course (Table Evii).

Although the majority (61.2%) of respondents who said they want to practise midwifery were educated in the United Kingdom, the proportion was smaller than that within the total group of respondents (75.7%). Larger proportions of those who would want to practise had taken their midwifery education in the West Indies, India, and the Philippines than the total group of respondents (Table Eii). The length of midwifery programs taken by those who want to resume their midwifery careers paralleled that reported by the total respondents. Seventy-nine percent (403) of the RNs had successfully completed programs six to twelve months long, and 73.7% of the RNAs (42) had taken programs 12 to 24 months long (Table Eiii). A smaller percentage of those wanting to practise midwifery (51.1%) were educated in hospital sponsored programs than the total respondents (79.9%); more of them (32.3% versus 10.7% of the total respondents) completed programs in independent schools of midwifery. The majority of the respondents (65.1%) who want to practise as midwives received certificates upon completion of their programs (Table Ev). The programs taken by these registrants combined theory with clinical practice; although the number of deliveries required to complete the program varied, the most frequently reported number was 20 (26.4%)—the same number of required deliveries most frequently reported by the total group of respondents (25.6%).

Midwifery Regulation

The regulation of midwifery practice is a complex matter. Registrants were only asked whether or not they had previously obtained a government or professional midwifery credential, and if so, which type (Table Dix). Certification was the most common credential identified by the total group of respondents (1986, 49.3%). Although many of the respondents who expressed an interest in resuming their midwifery practice had also been previously certified (194, 34.2%), a greater percentage of them (261, 46.0%) reported being registered (Table Eviii).

Registrants were not asked to provide other information regarding the regulation of their previous midwifery practice; however, they were asked to give their opinions on policy questions concerning the regulation of midwifery in Ontario. These findings are reported later.

Midwifery Work Experience

Information concerning the midwifery practice experience of RNs and RNAs in Ontario is pertinent to policy decisions regarding the education and regulation of midwives as well as their practice. In an effort to distinguish midwifery experience from the work experience of registrants in other maternity care roles, a midwife was defined with emphasis placed on the degree of responsibility assumed in the provision of the full scope of maternity care: antenatal, intrapartum, and postnatal care of well mothers and infants as well as health counselling and teaching. Registrants were asked to use this definition when answering the question concerning their midwifery and maternity care work experience.

Slightly more than half of the total respondents (2308, 51.1%) reported having practised as midwives (Table Fi). Therefore, the number of 1986 CNO registrants who have practised midwifery at some stage of their nursing careers was estimated to be between 3400 and 4200. A higher proportion of the RNA respondents (75.0%) than the RNs (50.2%) have had midwifery experience; nevertheless, the RN nurse-midwife group remains the largest subgroup of respondents. Two thousand and forty (2040) of the responding RNs who trained as midwives following their basic nursing education actually practised as midwives; 630 of the RN nurse-midwife group have never practised midwifery.

Seventeen percent of the RN and RNA respondents (782) said they had never practised midwifery even though they had taken some form of midwifery preparation (Table Fi). Almost 700 (686, 15.2%) of the respondents answered that they hadn't practised midwifery but had worked as maternal/infant nurses. Only 12 of these were RNAs, the rest were RNs. Six of the RN respondents (0.1%) had worked as public health nurses; 160 (3.7%) RNs had work experience as both maternal/infant nurses and public health nurses. The few comments offered by those who answered "other" did not suggest any additional maternity care roles.

The amount of experience among those who had actually practised midwifery was, as expected, rather limited. Seventy-three percent (72.8%, 1680) had less than five years experience; in fact, 23.5%, (542) had practised less than twelve months (Table Fii). Further evidence of the limited base of midwifery experience among CNO registrants was found in the analysis of the currency of their midwifery practice (Table Fiii). Only 15 respondents (.6%) reported actively practising midwifery in 1986. Forty-nine (2.1%) had worked as midwives within the past five years, but more than seventy-five percent of the respondents (1763, 76.4%) hadn't practised since 1975, over eleven years ago.

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[18] Information obtained from anecdotal comments of actual respondents.

The limited amount and outdated nature of the midwifery practice of RNs and RNAs in Ontario are the most important findings of the study in relation to midwifery work experience. These results reinforce earlier conclusions that most registrants with midwifery preparation and experience will require refresher courses or complete retraining if they wish to resume their practice as qualified midwives.

Respondents were also asked to provide information concerning the countries where they had practised midwifery, the practice settings in which they had worked, and the functions they had performed. Given that most of the respondents had received their midwifery preparation in the United Kingdom (U.K.) it was to be expected that the majority (61.1%) had also practised there (Table Fvi). The respondents with midwifery experience in the U.K. were primarily RNs (1140) and RNAs (28) who had acquired their midwifery qualifications following their basic nursing education. Very few respondents in the direct entry subgroups had practised midwifery in the U.K. Most of the direct entry respondents had been midwives in the Philippines.

Two hundred and seventy-five of the respondents (11.9%) had practised midwifery in Canada (Table Fvi). With the exception of 3 RNA respondents, they were all RNs. According to their comments, these registrants had practised as midwives in the Yukon, the Northwest Territories, and six of the provinces, including Ontario.

Although many of the respondents had practised midwifery in a number of different settings, over 90% (91.8%) had worked in hospitals (Table Fv). A higher proportion of RN respondents (92.9%) than RNAs (73.0%) had worked as midwives in hospitals, and a greater percentage of RNA respondents than RNs had functioned in the other identified practice settings. Over 1300 (59.5%) of the total respondents had conducted home births; 627 (27.2%) had worked in clinics or community health centres; 233 (10.1%) had been in outpost health services; 166 (7.2%) had worked with physicians in private practice; 101 (4.4%) had midwifery experience in birthing centres; and 49 (2.1%) had established their own private practices as midwives (Table Fv). The few comments provided by those reporting experience in other midwifery practice settings did not identify any additional major settings.

For the purposes of the survey, the scope of midwifery practice was categorized into eight functional areas which were validated in the pretest. Premature infant care was the only additional function identified by more than a few (11) of the respondents in their comments. Seven of the eight functions were found to have been performed by more than half of the RN and RNA respondents (Table Fiv); family planning was the one exception. Although 80 of the RNA respondents (63.5%) had provided family planning services, less than 40% of the RNs (835, 38.3%) had been involved in family planning as part of their midwifery practice.

Postpartum care was the midwifery function most frequently reported by the RNs (92.2%) and the RNA respondents (90.5%). Over 88% of both categories of respondents had also provided antenatal care. More than 2000 (2047, 88.7%) said they had offered intrapartum care including deliveries as part of their midwifery practice; almost that many (1757, 76.1%) indicated intrapartum care without deliveries had been included in their midwifery experience (Table Fiv). This finding is difficult to explain. It would suggest that most of the respondents had more than one experience as a midwife: one which included intrapartum care with deliveries and other(s) without.

In addition to describing the nature of their previous midwifery experience, respondents were asked to recall the number of years of experience they had in relation to each function. This was not a well-answered question. Since much of the midwifery practice had been many years ago, no doubt some of the respondents had difficulty remembering the length of their different midwifery experiences. The reported number of years of experience varied considerably and ranged from one to 35 years. With each function, one year of experience was the most commonly identified length of experience. The RN respondents averaged more experience than the RNAs in relation to each with the exception of family planning where the average length of experience of the RNA category was greater than that of the RNs.

The previous midwifery work experience profile of the respondents who indicated they want to practise midwifery was different compared with that of the total group of respondents. Whereas 51.1% of the total group had practised midwifery before, only 17.7% (110) of those who want to practise midwifery now had worked previously as midwives according to the provided definition (Tables Fi and Gi). Only 49 (9.0%) of the RNs had practised midwifery before; all of these came from the RN direct entry and RN Other subgroups (Table Gi). An unexpected and unexplainable finding was that none of the RN nurse-midwife group, all of whom reported successfully completing a midwifery program, had actually practised midwifery. They had worked as maternal-infant nurses, public health nurses, or in other areas of nursing, but not as midwives. Eighty-one percent of the RNAs (61, 81.3%) who said they want to practise midwifery had worked as midwives before.

The remaining analysis and discussion of the nature of the midwifery experience of the respondents who want to be able to practise midwifery pertains only to the responses of the 110 who reported having practised midwifery in the past.

The amount of midwifery experience reported by those who have worked as midwives and want to do so again was limited in the same way the experience of the total group of respondents was limited (Tables Fii and Gii). Sixty-five percent (71) had less than five years experience; 8 (7.3%) had less than a year; 30 (27.3%) had between one and two years of experience; and 33 (30.0%) said they had worked three to five years in midwifery. Only two RNs (1.8%) from the RN Other subgroup reported practising as midwives in 1986; 13 (11.8%) had practised within the past five years; but 73.7% (81) hadn't practised since 1975. This lack of recent midwifery experience is similar to that found in the total respondent group (Table Fiii and Giii).

It was interesting to find that within the group of respondents who expressed an interest in midwifery, a higher proportion had performed most of the midwifery functions than the total group of respondents (Table Fiv and Giv). This was especially so with respect to family planning where 39.6% of the total group reported having offered this service compared with 80.0% of the group who wanted to resume their midwifery practice. There were two functions (intrapartum care excluding deliveries, and postpartum care) which had been performed by a smaller proportion of the subgroup that reported an interest in practising midwifery as compared with the total number of respondents.

The setting of the previous midwifery practice of those who want to practise midwifery when it has been legalized differed in some respects from the settings in which the total group had practised (Table Fv and Gv). A smaller percentage of the group who want to practise midwifery had previously worked in hospitals (67.6% compared with 91.8%); larger percentages had conducted home births (71.3% compared with 59.5%) and worked in outpost health services (27.8% compared with 10.1%), birthing centres (12.0% compared with 4.4%) as well as midwifery private practices (26.9% compared with 2.1%). There were also differences in the distribution of responses by countries in which the respondents who want to practise midwifery in Ontario had practised midwifery before (Table Fvi and Gvi). A smaller percentage had practised in the United Kingdom (26.3% compared with 61.1%); however, larger percentages had previously worked in the West Indies (12.7% compared with 7.4%) and the Philippines (25.5%compared with 3.1%). Twelve percent of the total group of respondents reported practising midwifery in Canada; 17.3% of those who want to practise midwifery have already worked as midwives in Canada.

Midwifery Practice Preferences

In addition to gathering data on the previous midwifery preparation and work experience of CNO registrants, this study was designed to obtain information about the preferences of registrants concerning various midwifery policy issues. Respondents to the 1985 CNO survey were specifically asked whether they would want to practise as midwives when midwifery is legalized in Ontario.

Given the obvious interest in the policy preferences of those who are more likely to practise midwifery, the results of this section of the questionnaire have been reported primarily in terms of the respondents who have indicated a desire to practise midwifery (Appendix H). An analysis of the responses from the total group of respondents was also carried out and where appropriate certain findings have been included in this discussion.[19]

As previously reported, 621 respondents expressed definite interest in practising as midwives when it becomes legal in Ontario to do so. This group represents less than fourteen percent (13.7%) of the 4514 respondents (Table Hi). Applying the same two inflation factors, 1.5 and 1.8, it was estimated that 900 to 1200 of the 1986 CNO registrants with previous midwifery preparation would want to practise midwifery. It may be assumed, and is important to note, that there are other CNO registrants who have not had midwifery preparation, and therefore were not part of the 1985 and 1986 studies, but who would want to become midwives when given the opportunity. There have been no studies which suggest the size of this group.

In addition to the respondents who replied "yes" to the question asking about their desire to practise midwifery, there were more who responded "maybe/depends" or "don't know". A total of 1564 (34.7%) reflected some measure of uncertainty regarding their interest in resuming their midwifery practice. Among the many comments offered in association with this question, there were concerns expressed about the need for accessible and affordable refresher programs, the threat of lawsuits, the cost and availability of malpractice insurance, and the lack of adequate support systems for home births. For many, the decision to practise midwifery in Ontario would be influenced by how the practice of midwifery is legally defined, the actual opportunities for employment, the expected income, and the degree of public acceptance.

Given the previously reported findings of the limited amount of recent midwifery experience and education of CNO registrants, it was not surprising to learn that many respondents would not want to practise midwifery again. Over forty percent of the respondents (43.2%, 1949) indicated they were not interested in practising as a midwife; a review of the comments suggested some of the reasons why not. A number of respondents said they were retired, close to retirement age, or too old to consider returning to active midwifery practice. Others stated that when they had immigrated to Canada and had not been able to practise midwifery, they had been forced to seek employment in other clinical areas such as oncology, gerontology, and community health, which they now enjoyed and wouldn't want to leave.

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[19] Other findings from this analysis are available from the College of Nurses of Ontario.

A further examination of the results revealed that a higher proportion of the RNA respondents than the RNs want to return to midwifery practice (Table 5). Within the much larger group of RN respondents, only twelve percent (11.5%, 465) of the RN nurse-midwife subgroup expressed an interest in resuming their careers as midwives; 45% (1815) definitely said no; and 34% (34.2%, 1380) were uncertain.

TABLE 5. NUMBER AND PERCENTAGE OF RESPONDENTS WHO WANT TO PRACTISE MIDWIFERY WHEN IT IS LEGALIZED IN ONTARIO

SUBGROUPS	YES		MAYBE/ DEPENDS		NO		DON'T KNOW		NO RESPONSE		TOTAL	
	No.	%	No	%	No	%	No.	%	No.	%	No.	%
RN NURSE-MIDWIFE	465	11.5	1080	26.8	1815	45.0	300	7.4	375	9.3	4035	100.0
RN DIRECT ENTRY	21	29.2	6	8.3	33	45.8	12	16.7	0	0.0	72	100.0
RN OTHER	60	25.1	76	31.8	83	34.7	17	7.1	3	1.3	239	100.0
RN TOTAL	546	12.6	1162	26.7	1931	44.4	329	7.6	378	8.7	4346	100.0
RNA NURSE-MIDWIFE	35	47.3	28	37.8	7	9.5	2	2.7	2	2.7	74	100.0
RNA DIRECT ENTRY	30	39.0	32	41.6	11	14.3	4	5.2	0	0.0	77	100.0
RNA OTHER	10	58.8	5	29.4	0	0.0	2	11.8	0	0.0	17	100.0
RNA TOTAL	75	44.6	65	38.7	18	10.7	8	4.4	2	1.2	168	100.0

Policy statements. The respondents were asked to indicate the degree to which they agreed or disagreed with five policy statements. Almost 80% (78.9%) of the RN and RNA respondents who want to practise midwifery strongly agreed that midwifery should be a nursing specialty requiring specialized preparation following basic nursing education (Table Hii). Over 50% (53.6%) also strongly agreed that midwifery should be recognized as an independent profession with separate educational programs and its own regulatory agency. This pattern of response among those respondents who want to resume their careers as midwives was the same for the total group of respondents. A detailed analysis of the responses to these policy statements revealed that 3074 (70.7%) of the total RN respondents agreed with both statements as did 114 (67.9%) of the total RNAs. Only 744 (16.5%) of the total RN and RNA respondents agreed that midwifery should be a nursing specialty, but disagreed that midwifery should be an independent profession. Therefore, it is important to note that among the CNO registrants, the majority of those with midwifery preparation consider midwifery to be a nursing specialty but believe it ought to be recognized as an independent profession.

On the question of whether qualified midwives who are not nurses should be allowed to practise in Ontario, the respondents who want to practise midwifery were generally in favour of the policy; 42.7% agreed with the statement (Table Hii). This was a more favourable finding than the response of the total respondent group where only 34% agreed with the statement and 47% disagreed; in fact, 34% strongly disagreed. The RNs and RNAs who want to resume their midwifery careers reacted much the same way to the statement that midwives who are not nurses should be allowed to deliver babies in hospitals as they did to the previous policy statement. The total group of respondents were not as supportive of this policy as were those who want to practise midwifery; however, more agreed with this statement than the previous one. These findings are contradictory and not readily explained.

The fifth policy statement focused on the issue of home births rather than the question of nurse-midwifery versus direct entry midwifery. The majority of those who want to practise midwifery (61.0%) strongly agreed that any qualified midwife should be permitted to conduct home births. The total group of respondents were not as supportive of this policy; however, 49.8% did agree with the statement.

Practice options. The RN and RNA respondents who want to practice midwifery clearly favour independent/private practice with one or more physicians over the other two models of independent/private practice (Table Hiii). In fact, this was the practice option preferred most by the RNs. In contrast, the RNA respondents expressed a preference for working as employees in a hospital, clinic/community health facility, birthing centre, or doctor's office rather than establishing private practices. The model of practice least favoured by both categories of respondents interested in resuming their midwifery careers was the solo practice option; only 6.3% were in favour of this option and 61.2% were opposed. As was expected, those interested in practising midwifery expressed more favourable opinions about the various practice options than did the total group of respondents.

Number of clients. Assuming that some of the respondents would want to establish private midwifery practices, the Task Force wanted to know how many clients these respondents would want to manage per year. One hundred and seventeen of the respondents (18.8%) said they were not interested in independent practice and 191 (30.8%) of those that were interested didn't know how many clients they wanted to manage in a year (Table Hiv). Nevertheless, 181 (29.2%) said they would want more than 100 clients per year; 175 of these were RNs. Ninety-five (15.3%) thought they could manage 50 to 99 clients per year; only twenty (3.2%) indicated they would want less than 50 clients per year. In general, the RNs were prepared to manage more clients per year than were the RNAs.

Willingness to take a refresher course. Most of the RNs or RNAs who want to practise midwifery (455, 73.3%) said they would be willing to take a refresher course of three to six months duration (Table Hv); none refused. Nevertheless, the respondents raised some concerns regarding the cost and accessibility of refresher programs. It was suggested that the government or employers should assume the cost of refresher programs. Respondents also identified work and family commitments as barriers to attending refresher programs. Part-time programs were proposed as one solution. As expected, the total group of respondents differed from those who want to practise midwifery in that fewer were willing to enrol in a refresher program and many were not interested.

Methods of payment. This question was not as well answered as the others. Many of the respondents did not reply (Table Hvi). Payment by salary was the method preferred by the largest percentage of the respondents who want to practise midwifery (418, 67.3%). Very few expressed interest on being paid by clients directly on a fee-for-service basis (41, 6.6%). Almost 250 (40.1%), however, were interested in having their services covered by OHIP.

Distribution of services. The geographic distribution of human resources is always a critical issue in health manpower planning. This study did not effectively determine the potential distribution of midwifery services by those who want to practise. Most of the RN and RNA respondents (585, 94.2%) indicated they would prefer to practise where they currently reside rather than move to another place (Table Hvii).

Basic midwifery education. Two questions offered various basic education options for the preparation of midwives; one question addressed appropriate programs to prepare midwives who are nurses, and the other identified programs to prepare those who aren't. The respondents who want to practise midwifery in Ontario identified post-basic certificate programs as the appropriate type of program for beginning midwives with nursing backgrounds. More RNs (36.8%) preferred post-basic programs offered by universities or Ryerson Polytechnical Institute (Ryerson), while the majority of RNAs (62.7%) chose post-basic certificate programs offered by the Colleges of Applied Arts and Technology (C.A.A.T.). Only 33 respondents (5.3%) preferred a post-RN baccalaureate degree program offered by a university or Ryerson and even fewer (13, 2.1%) identified a master's degree as the appropriate basic program to prepare nurse-midwives. A number of respondents, especially the RNs, commented on the importance of adequate clinical practice and suggested the need to combine an apprenticeship program with one or more of the other options.

A diploma program offered by a C.A.A.T. was the model of basic preparation considered appropriate for non-nurse midwives (direct entry) by the largest percentage of RN and RNA respondents (200, 32.2%) (Table Hix). A baccalaureate degree program from a university or Ryerson was the next most frequently chosen option (105, 16.9%). Fourteen percent (77) of the RNs who want to practise midwifery and seventeen percent (717) of the total group of RN respondents added comments to suggest that a nursing program was a required foundation on which to build entry level midwifery knowledge and skills.

Comparing the types of programs considered appropriate for nurse-midwives with those chosen for direct entry midwives, (Tables Hviii and Hix), it was noted that more respondents (105, 16.9%) supported a baccalaureate midwifery program for non-nurses than they did for the nurses (33, 5.3%). In addition, a formal apprenticeship program was more frequently seen to be appropriate for nurses (155, 25.0%) than for non-nurses (67, 10.8%). While it is not surprising that nurses who care about midwifery and the qualifications of those who practise it should favour a baccalaureate program entry-level midwifery preparation for non-nurses, it is significant that they don't perceive the need for the same level of preparation for themselves, at least not to the same extent.

The final question in the study was designed to obtain opinions on whether or not midwives should be trained and permitted to perform certain procedures. The question was reasonably well answered although some respondents needed to qualify their choices. For example a few respondents stated midwives should not repair third-degree lacerations. No doubt there are many conditions under which midwives should or should not perform these procedures. Such conditions were not defined in the question nor were respondents asked to specify the conditions assumed in their choice. A majority of both RN and RNA respondents supported the training of midwives to carry out the following procedures: perform episiotomy, conduct initial assessment of the newborn, order common diagnostic procedures, repair episiotomy or skin laceration, administer local anesthetic, and prescribe common medications (Table Hx). Respondents who want to be midwives did not support the use of vacuum extractors or forceps; to a lesser extent they were opposed to midwives intubating the newborn and performing an amniotomy. The pattern of response of the total group of respondents paralleled that of those who want to practise midwifery with one exception—half of the total group were prepared to allow midwives to intubate the newborn. Indeed, 49.3% (37) of the RNAs who want to resume their midwifery practice also expressed this view; however, 62.5% of the larger RN group (341) indicated midwives should not perform this procedure.

The back page of the questionnaire was left blank for comments and respondents were encouraged to submit additional views regarding the education, practice, and regulation of midwifery. Quite a few chose to do so. These comments have not been systematically analyzed or reported here; however, they are available for review at the College of Nurses of Ontario.

CONCLUSIONS

As a result of this study, information that describes the previous midwifery education and practice experience of RNs and RNAs in Ontario is now available. The results of the survey of a randomly selected sample of 1986 College of Nurses registrants produced estimates of 6.1% and 7.3% of the registrant body with some form of midwifery preparation. These findings are significantly different from the results of the 1985 CNO midwifery survey in which 4.0% reported previous midwifery training. Although the number of registrants with midwifery preparation and experience appears large, relatively few have taken a midwifery course since 1980 or worked as midwives within the past five years. From a policy perspective, these findings reinforce the already identified need for refresher programs as well as basic midwifery education programs. Given that over eighty percent of the registrants with midwifery preparation completed their midwifery studies more than fifteen years ago, it may be necessary to consider requiring registrants to repeat their basic midwifery education. Such a requirement would affect the relative demand for enrolment in basic programs rather than refresher courses.

The study also served to identify the number of registrants with midwifery backgrounds who say they want to practise as midwives when midwifery is legally introduced into the Ontario health care system. On the basis of the results of both surveys it was estimated that betweem 900 and 1200 registrants want to practise midwifery; this includes both RNs and RNAs. It is important to reiterate that this study does not address the question of the number of RNs and RNAs who do not have midwifery backgrounds but also want to qualify as midwives when it is possible to do so.

The midwifery education and work experience of the survey respondents who want to practise midwifery was examined. Although 91.3% had successfully completed a program, only 17.7% had actually practised midwifery. Compared to the total goup of respondents, the proportion of those with previous midwifery experience was considerably smaller. The distribution of responses of those who indicated a desire to practise midwifery differed from that of the total group with respect to the settings in which they had practised as well as the countries where they had worked as midwives. Other differences between the two groups were less noteworthy.

In response to questions concerning midwifery policy issues CNO registrants with midwifery preparation who want to practise as midwives clearly expressed their views. Generally they believe midwifery should be a nursing specialty requiring specialized preparation following basic nursing education. They also believe midwifery should be recognized as an independent profession. Although these positions are thought to be mutually exclusive by some, they are obviously not considered so by the participants in this study. In addition, these registrants who say they want to practise midwifery support qualified midwives who are not nurses being allowed to practise in Ontario; they also agree with qualified midwives who are not nurses being allowed to deliver babies in hospitals. Finally, the opinion of the majority favoured permitting qualified midwives to conduct home births. The views of these registrants differ from the positions of the College of Nurses.

The opinions of the registrants with respect to appropriate midwifery education programs reflect the current approach to specialty preparation in nursing. Given the opportunity to choose or propose alternative educational models, the registrants prefer the traditional and familiar diploma or post-basic certificate program format. Their concerns regarding the cost and accessibility of midwifery programs are the same concerns voiced by RNs and RNAs about continuing nursing education generally.

Throughout the report differences between the RNs and RNAs have been noted. In particular, RNAs differ from RNs in their preferences regarding practice options. The RNAs, more than the RNs, favoured options in which the RNA assumed the role of an employee. The option most strongly favoured by the RNs was independent or private practice with physicians. Interestingly, neither category expressed much interest in establishing solo practices for themselves.

It should be said, in closing, that the sustained interest in and commitment to midwifery among the registrants who participated in this study was evident throughout their responses and comments. The excellent rate of response to the questionnaires also reflects the degree of interest and concern surrounding the midwifery issues currently being addressed by the College of Nurses and the Task Force on the Implementation of Midwifery in Ontario.

Appreciation is extended to all those who participated in this study.

REFERENCES

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Dillman, D. (1978). *Mail and Telephone Surveys.* New York: John Wiley and Sons.

Ferguson, G. (1966). *Statistical analysis in psychology and education.* New York: McGraw-Hill.

APPENDIX A

The report of the registrant survey (pp. 38-45).
Included in *Midwifery—A CNO Policy Background Paper* (1986).
Toronto: College of Nurses of Ontario.

REGISTRANT SURVEY

Purposes

In many of the discussions concerning the practice of midwifery some important information has been missing. No one has an accurate count of the number of midwives in Ontario. The exact number of lay-midwives is not known nor has the College of Nurses had statistics on the number of registered nurses (RNs) and registered nursing assistants (RNAs) who have had midwifery preparation. Given that the practice of midwifery has not yet been legalized, the number of currently practising midwives has only been estimated. Information concerning the supply of and demand for midwives is pertinent to most of the issues surrounding midwifery.

In the fall, it was decided that the College of Nurses would take advantage of the annual process of membership renewal to gather some basic data on the number of midwives among the RN and RNA registrants. The primary purpose of the registrant survey was the determination of the number of CNO registrants who are, or previously have been, midwives. A secondary objective was the identification of RN and RNA midwives for the purposes of future data collection should additional information be required.

Methodology

The annual renewal of membership in the College of Nurses is conducted throughout the fall, starting in October with the mailing of the RN and RNA renewal forms. In 1985, approximately 136,000 forms were sent out. Since the forms are prepared months in advance, a question concerning midwifery could not be added to the form. It was possible, however, to enclose an information slip in the renewal package.[1] The registrants were requested to return the completed slip with their renewal form. Responses were manually sorted and tabulated by the Monitoring and Evaluation research assistant as they were returned. Most of the information slips were returned before the December 31 membership expiry date. The continuing return of a few slips necessitated setting January 31, 1986 as the deadline for the purpose of tabulating the results.

Results

A total of 5409 usable midwifery slips were returned; 5167 were received from RNs, and 242 were completed by RNAs. In addition to the 5409 responses reported in Table 1, the College received slips from 84 registrants (RN and RNA combined) who have not had midwifery preparation but used their slips to express their opinion on the issue of recognizing midwifery in Ontario.

In order to encourage a good response rate, the midwifery slip question was kept short and straight forward. The registrants were asked whether they are or have been a midwife. In addition, they were asked to indicate whether they acquired formal midwifery education after their nursing education which would make them a nurse-midwife, or before their nursing education. An "other" category was provided for registrants who had acquired midwifery knowledge and skill in an apprenticeship program or some different type of preparation. A definition of midwifery was not provided; consequently, the respondents were free to define midwifery as they chose. A few RNs and RNAs who have practised in labour and delivery areas used the "other" category to report their involvement in maternal-infant nursing. Although these RNs and RNAs have not had formal midwifery preparation they were included in the count because it was interpreted that they perceive themselves to be midwives, or they see themselves carrying out some of the functions of a midwife.

TABLE 1. RESPONSES TO CNO REGISTRANT SURVEY

TYPE OF MIDWIFERY	RN		RNA		TOTAL	
PREPARATION	NO.	%	NO.	%	NO.	%
Acquired formal midwifery education *after* nursing education	4763	92.2	103	42.6	4866	90.0
Acquired formal midwifery education *before* nursing education	85	1.6	102	42.1	187	3.4
Other	319	6.2	37	15.3	356	6.6
TOTAL	5167	100.0	242	100.0	5409	100.0

Formal midwifery preparation. The majority (92.2%) of the 5167 RN registrants with midwifery preparation reported acquiring their midwifery education after their nursing education (Table 1). Only eighty-five RNs (1.6%) were direct entry midwives before becoming nurses. The RNA registrants were evenly distributed between the two types of formal midwifery education: 103 (42.6%) were prepared as midwives after their nursing education, and 102 (42.1%) trained as midwives first. The registrants were not asked to provide information regarding the date and location of their midwifery education. Therefore, the currency of the midwifery knowledge and skills among the registrants is not known, nor does the College have complete data on the country of origin of their midwifery training. This is information that could be obtained by a follow-up survey if it was required.

Country of midwifery preparation. Some of the respondents volunteered information regarding where they did their midwifery training. Although the data are incomplete, the findings give some indication of the countries where registrants have obtained their midwifery preparation. This information is presented in Tables 2 and 3.

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[1] See Appendix C for copies of the midwifery information slip and covering letter.

TABLE 2. THE COUNTRIES WHERE SOME OF THE RNs OBTAINED THEIR MIDWIFERY PREPARATION

TYPE OF MIDWIFERY	Country Not Identified		United Kingdom		India		Australia & New Zealand		All Others		Total	
	No.	%*	No	%*	No	%*	No.	%*	No.	%*	No.	%*
Nurse-Midwifery	3266	68.6	1237	26.0	100	2.1	46	.9	114	2.4	4763	100.0
Direct Entry Midwifery	57	67.1	2	2.3	1	1.2	1	1.2	24	28.2	85	100.0
Other	146	45.8	13	4.1	17	5.3	6	1.9	137	42.9	319	100.0
TOTAL	3469	67.2	1252	24.2	118	2.3	53	1.0	275	5.3	5167	100.0

*Row percents

TABLE 3. THE COUNTRIES WHERE SOME OF THE RNAs OBTAINED THEIR MIDWIFERY PREPARATION

TYPE OF MIDWIFERY	Country Not Identified		United Kingdom		India		Australia & New Zealand		All Others		Total	
	No.	%*	No	%*	No	%*	No.	%*	No.	%*	No.	%*
Nurse-Midwifery	65	63.1	25	24.3	3	2.9	2	1.9	8	7.8	103	100.0
Direct Entry Midwifery	62	60.8	1	1.0	0	0.0	0	0.0	39	38.2	102	100.0
Other	20	54.1	1	2.7	1	2.7	0	0.0	15	40.5	37	100.0
TOTAL	147	60.8	27	11.2	4	1.6	2	.8	62	25.6	242	100.0

*Row percents

Most of the 1698 RNs who identified their source of midwifery preparation were trained as nurse-midwives in the United Kingdom (1237 RNs), India (100 RNs) or Australia and New Zealand (46 RNs). One hundred and fourteen (114) RNs reported receiving midwifery education in twenty-seven other countries or regions such as the West Indies (25 RNs), Hong Kong (29 RNs), and South Africa (13 RNs). Eight RNs were educated as nurse-midwives in the United States. The number of direct entry midwives among the RN registrants is small (85) and only 28 stated the location of their midwifery preparation. Nine of them were trained as midwives in the Philippines, four were educated in the West Indies, and the remaining ones received their preparation in twelve different countries.

As with the RN registrants, the majority of the RNA nurse-midwives were prepared in the United Kingdom (25 RNAs). A larger proportion of the RNAs were direct entry midwives before taking their nursing education. Twenty-eight of the 39 direct entry RNAs educated in other countries reported training as midwives in the Philippines.

Most of the RN and RNA registrants who responded to the "other" category of midwifery preparation did not provide explanatory comments. The largest group that did were the 79 RN registrants who described the midwifery-related preparation they had obtained in Canada. Twenty-one (21) of these RNs had taken the Certificate in Advanced Practical Obstetrics previously offered by the University of Alberta, 18 were graduates of the Dalhousie University Outpost and Community Health Program, and one had completed the Diploma of Midwifery Program offered at Memorial University of Newfoundland. Sixteen reported acquiring on-the-job midwifery training while working in outpost hospitals and other remote areas. Two RNs said they had taken the Obstetrics Program at Humber College, and two others stated they were currently involved in apprenticeship training with a lay midwife.

Opinions regarding the recognition of midwifery in Ontario. Even though the registrants were not asked to express their preferences concerning the recognition of midwifery, some of them took the opportunity to do so. Seventy-seven of the respondents with midwifery preparation volunteered their opinion and, as previously reported, 84 RNs and RNAs who did not have any form of midwifery training returned the midwifery slip with their comments (Table 4).

Over 90% of both groups indicated they favoured the legalization of midwifery and only 11 registrants out of the 161 who expressed their opinion were opposed. These nurses do not constitute a representative sample of the College registrants. Readers are cautioned not to interpret these findings as generalizable to the total population of RNs and RNAs in Ontario.

TABLE 4. OPINIONS OF CNO REGISTRANTS REGARDING THE RECOGNITION OF MIDWIFERY

OPINION	IN FAVOUR		OPPOSED		TOTAL	
GROUPS	NO.	%*	NO.	%*	NO.	%*
Registrants with Midwifery Preparation	74	96.1	3	3.9	77	100.0
Registrants without Midwifery Preparation who Submitted Comments	76	90.5	8	9.5	84	100.0
TOTAL	150	93.2	11	6.8	161	100.0

*Row percents

Comment

More precise midwifery manpower data are required in order to plan educational programs and regulatory mechanisms. The results of this survey constitute the foundation of an information base upon which to build a system of collecting, analyzing, and reporting up-to-date, complete midwifery manpower statistics.

APPENDIX B

Covering Letter and Questionnaire for Survey I

July 21, 1986

Dear Colleague:

Last autumn, the College of Nurses conducted a survey of RN and RNA registrants to determine how many are, or previously have been, midwives. The survey was carried out in conjunction with the regular CNO annual renewal process. An information slip was inserted in the renewal form package and you were one of over 5400 registrants who completed the slip and returned it with your renewal form.

As you may recall, you were not asked to provide detailed information at that time. Since then, the Ministry of Health has established the Task Force on the Implementation of Midwifery in Ontario to study and make recommendations concerning the education, practice, and regulation of midwifery. Now the Task Force and the College of Nurses require more specific information about the previous midwifery education and work experience of registrants. This information will assist both groups to formulate public and professional policy. We are also interested in your opinions regarding some important midwifery issues.

The College of Nurses and the Task Force on the Implementation of Midwifery in Ontario are co-sponsoring this follow-up survey of registrants. Your name has been selected from among the 5400 registrants who responded to the initial survey. We would appreciate your completing the enclosed questionnaire and returning it in the prepaid envelope provided *before August 15, 1986*.

Given the importance of the information, we hope that everyone will return their questionnaire. We plan to send reminder notices to those who do not respond. The address label on the questionnaire itself will allow us to identify those who have responded and those who have not. Even though your name is on the questionnaire, we want to assure you that your information will be treated confidentially and the findings will be reported anonymously. If you prefer, you may cross out your name and address before returning the questionnaire but please leave your CNO registration number which we need to use as your computer code number.

Thank you for your co-operation and much appreciated assistance.

Sincerely,

Kathleen M. Clark, R.N.
Co-ordinator
Monitoring and Evaluation

MIDWIFERY SURVEY

Last autumn the College of Nurses included an information slip in the registrant renewal package for the purpose of identifying RNs and RNAs who are, or have been, midwives. You kindly completed the slip and returned it with your renewal form. Thank you.

Since then the Ministry of Health has established the Task Force on the Implementation of Midwifery in Ontario to study and make recommendations concerning the education, practice, and regulation of midwifery. Now the Task Force and the College of Nurses require more specific information about the previous midwifery education and work experience of registrants. We are also interested in your opinions regarding some of the important midwifery policy issues.

The College of Nurses and the Task Force on the Implementation of Midwifery in Ontario are co-sponsoring this follow-up survey of registrants. We ask that you complete the questionnaire as soon as possible and return it to us in the prepaid envelope provided. We would appreciate receiving your reply *before August 15, 1986.*

We have used your CNO registration number to code your questionnaire so that reminder notices can be sent to those who do not respond. Your responses will be treated confidentially and reported anonymously. Given the importance of the information, we hope that everyone will return their questionnaire. We want to thank you for your cooperation and much appreciated assistance.

Please do not remove the following address label. It includes your code number as we explained above.

MIDWIFERY EDUCATION

Basic (Beginning) Midwifery Education

1. Have you successfully completed a midwifery education program? (Circle one number)

1. Yes (Please proceed with question **2**)
2. No, but I have taken a course in advanced maternal and infant nursing (Please provide the following information about the course you took and then proceed to question **11**)
   a. Year of completion? ______
   b. Location of program? ______
   c. Length of program? ______
   d. Comment? ______
3. No (Please proceed to question **11**)
4. Other (Please comment) ______

______

2. In which country did you complete your basic midwifery education? (Circle one number)

1. Australia
2. India
3. Ireland
4. United Kingdom
5. United States
6. Other (Please specify) ______

3. How long was the midwifery program? (Circle one number)

1. Less than six months
2. Six months to one year
3. More than one year to two years
4. More than two years

4. What year did you complete this program? (Circle one number)

1. 1980 to 1986
2. 1970 to 1979
3. 1960 to 1969
4. Before 1960

5. Upon completion of the midwifery program did you receive one of the following forms of recognition from the institution sponsoring the program? (Circle one)

1. Certificate
2. Diploma
3. Bachelor's Degree
4. Master's Degree
5. Other (Please specify) ______

6. What type of institution sponsored the midwifery program? (Circle one)

1. Hospital
2. College
3. University
4. Independent school of midwifery
5. Other (Please specify) ______

7. How would you describe the program? (Circle one)

1. Theory (classroom) only
2. Clinical experience only
3. Combination of theory and clinical experience

8. How many babies were you required to deliver (not just observe births) for completion of the program? ______

Continuing Midwifery Education

9. Have you taken a midwifery refresher course? (Circle one)

1. No
2. Yes ... Year course was taken? ____________________

10. Regulation

Following completion of your basic midwifery education, did you obtain one of the following forms of government or professional midwifery credential? (Circle one)

1. Did **NOT** obtain a government or professional midwifery credential
2. Certification
3. Licensure
4. Registration
5. Other (Please specify) ________________________

WORK EXPERIENCE IN MATERNITY CARE

For the purpose of this survey, a midwife has been defined as: a person who provides on her own responsibility antenatal, intrapartum and postnatal care of essentially well mothers and infants, including health counselling and teaching.

11. Have you practised as a midwife according to the above definition? (Circle as many as appropriate)

1. Practised as a midwife (Please answer questions **12** to **16**)
2. Never practised as a midwife
3. Practised as a maternal/infant nurse, but not as a midwife
4. Practised as a public health nurse/ health visitor, but not as a midwife
5. Other (Please specify) ________________________

If you circled option 2, 3, 4, or 5 please proceed to question 17.

12. How many years (total) have you practised as a midwife? (Circle one)

1. Less than one year
2. One to two years
3. Three to five years
4. More than five years

13. What year did you last practise as a midwife? __________

14. The following are the major functions of a midwife. With your total midwifery experience in mind (not student experience), circle all the functions you have performed throughout your midwifery career. In addition, please estimate to the nearest year the amount of experience you have had in relation to each function you circled.

Midwifery Functions	*Years of Experience*
1. Antepartum care	1a __________
2. Prenatal classes	2a __________
3. Intrapartum care *excluding delivery*	3a __________
4. Intrapartum care *including delivery*	4a __________
5. Postpartum care	5a __________
6. Family planning	6a __________
7. Well woman health care	7a __________
8. Well infant care	8a __________
9. Other (Please specify) ______________	9a __________

15. In which of the following settings have you practised as a midwife? (Circle as many as appropriate)

1. Home births
2. Clinic/community health centre
3. Physician private practice
4. Midwife private practice
5. Birthing centre
6. Hospital
7. Outpost health service
8. Other (Please specify) ________________________

16. In which country/countries have you practised as a midwife? (Circle as many as appropriate)

1. Australia
2. Canada (Please specify province(s) or territory) ________________________
3. India
4. Ireland
5. United Kingdom
6. United States (Please specify state) ______________
7. Other (Please specify) ________________________
____

MIDWIFERY PRACTICE PREFERENCES

17. Please indicate by circling the number in the appropriate column, the extent to which you agree or disagree with the following statements.

STATEMENTS	STRONGLY AGREE	SOMEWHAT AGREE	DON'T KNOW	SOMEWHAT DISAGREE	STRONGLY DISAGREE
1. I believe midwifery should be recognized as an independent profession with separate educational programs and its own regulatory agency.	1	2	3	4	5
2. I believe midwifery should be a nursing specialty requiring specialized preparation following basic nursing education.	1	2	3	4	5
3. I believe qualified midwives who are not nurses should be allowed to practise in Ontario.	1	2	3	4	5
4. I believe qualified midwives who are not nurses should be allowed to deliver babies in hospitals.	1	2	3	4	5
5. I believe any qualified midwife should be permitted to conduct home births.	1	2	3	4	5

18. When the practice of midwifery is legalized in Ontario, would you want to practise as a midwife? (Circle one)

1. Yes
2. Maybe/Depends (Please comment) ____________________
3. No
4. Don't know (Please comment) ____________________

Comments? ____________________

19. If you were to practise as a midwife, please indicate your personal preferences regarding the following midwifery practice options. (Circle one number per option)

PRACTICE OPTIONS	STRONGLY IN FAVOUR OF THIS OPTION	SOMEWHAT IN FAVOUR OF THIS OPTION	UNDECIDED	SOMEWHAT OPPOSED TO THIS OPTION	STRONGLY OPPOSED TO THIS OPTION
1. Independent/private practice with other midwives (group practice)	1	2	3	4	5
2. Independent/private practice by yourself (solo practice)	1	2	3	4	5
3. Independent/private practice with physician(s)	1	2	3	4	5
4. Practising with a physician in a doctor's office as an employee	1	2	3	4	5
5. Practising in a birthing centre as an employee	1	2	3	4	5
6. Practising in a clinic or community health facility as an employee	1	2	3	4	5
7. Working scheduled shifts as an employee in a hospital	1	2	3	4	5

20. If you would be interested in one of the above independent/private practice options, how many clients do you think you would want to manage per year? (Circle one)

1. I'm not interested in the independent/practice options
2. Less than 25 clients per year
3. 25 to 49 clients per year
4. 50 to 99 clients per year
5. More than 100 clients per year
6. Don't know

21. Would you be willing to take a refresher course (that might be 3-6 months duration) in order to practise as a qualified midwife? (Circle one)

1. Yes
2. Maybe/Depends (Please comment)
3. No
4. Don't know (Please explain this response by identifying the factors that would enable or prevent you taking a refresher course)

Comments? ______________________________

____

____

22. If you were to practise as a midwife, please indicate your *personal preferences* regarding the following methods of payment. (Circle one number per option)

METHOD OF PAYMENT	STRONGLY PREFER	SOMEWHAT PREFER	UNDECIDED	SOMEWHAT OPPOSE	STRONGLY OPPOSE
1. Salary	1	2	3	4	5
2. Fee for service paid directly by clients	1	2	3	4	5
3. Fee for service covered by OHIP	1	2	3	4	5

23. Where would you want to practise midwifery? (Circle one)

1. Where I live now
2. In another place (Please specify) ______________

24. What do you consider the appropriate basic educational preparation for a beginning (entry level) midwife who is a nurse? (Circle as many as appropriate)

1. Post-RN baccalaureate degree program offered by a university or Ryerson Polytechnical Institute
2. Master's degree program offered by a university
3. Post-basic certificate program offered by a college of applied arts and technology
4. Post-basic certificate program offered by a university or Ryerson Polytechnical Institute
5. A formal apprenticeship program
6. Other (Please specify) ______________

25. What do you consider the appropriate basic educational preparation for a beginning (entry level) midwife who is NOT a nurse? (Circle as many as appropriate)

1. Diploma program offered by a college of applied arts and technology
2. Baccalaureate degree program offered by a university or Ryerson Polytechnical Institute
3. Master's degree program offered by a university
4. A formal apprenticeship program
5. Other (Please specify) ______________

26. Please indicate whether or not you believe midwives should be trained and permitted to perform the following procedures. (Circle one)

1. Use vacuum extractor	1. Should	2. Should not
2. Use forceps	1. Should	2. Should not
3. Perform episiotomy	1. Should	2. Should not

4. Repair episiotomy or skin laceration 1. Should 2. Should not
5. Conduct initial assessment of newborn 1. Should 2. Should not
6. Intubate newborn 1. Should 2. Should not
7. Perform amniotomy 1. Should 2. Should not
8. Administer local anesthesia 1. Should 2. Should not
9. Order common diagnostic procedures 1. Should 2. Should not
10. Prescribe common medications 1. Should 2. Should not

We would welcome any additional comments you care to make regarding the education, practice, and regulation of midwifery.

THANK YOU FOR YOUR COOPERATION.

APPENDIX C

Covering Letter and Information Slip for Survey II

July 21, 1986

Dear Colleague:

Last autumn, the College of Nurses conducted a survey of RN and RNA registrants to determine how many are, or previously have been, midwives. An information slip was inserted in the CNO annual renewal form package and over 5400 registrants completed and returned the slip. At that time, we only asked registrants with midwifery preparation to return the slip.

This summer the College of Nurses is cosponsoring with the Ministry of Health Task Force on the Implementation of Midwifery in Ontario, a follow-up study of the previous midwifery education and work experience of registrants. The follow-up study will involve a survey of some of the 5400 registrants who returned the midwifery information slip in the fall.

In addition, we need to evaluate the accuracy of the response rate to the midwifery information slip. We are doing that by mailing out another information slip to a randomly selected sample of RNs and RNAs from CNO's total registrant body. Your name was one of those chosen from the list of current registrants.

We would sincerely appreciate you completing the enclosed information slip and returning it in the prepaid envelope provided before August 15, 1986. The slip is the same as the one distributed in the fall with one important difference. Registrants who have NOT had midwifery preparation and are NOT midwives are also being asked to complete the slip and return it. In other words, EVERYONE who receives the slip is being asked to fill it out and send it back.

Because it is so important that we receive as many returns as possible, we will be sending out reminder notices to those who do not respond. The address label on the slip will allow us to identify those who have responded and those who have not. Even though your name is on the slip, we want to assure you that your information will be treated confidentially and your responses reported anonymously.

Thank you for your co-operation and much appreciated assistance.

Sincerely,

Kathleen M. Clark, R.N.
Co-ordinator
Monitoring and Evaluation

COLLEGE OF NURSES OF ONTARIO
MIDWIFERY INFORMATION SLIP

In order to evaluate the accuracy of the response rate to a previous midwifery information slip, a randomly selected sample of RNs and RNAs are being asked to complete another slip. Your name was one of those chosen from the list of current registrants.

Please answer the following questions and return this information slip in the prepaid envelope provided before August 15, 1986. The address label at the bottom will allow us to identify those who return their slips. Because it is important to encourage everyone to respond, we will be sending reminder notices to those who do not return their slips. We want to assure you that the information you give us will be treated confidentially and reported anonymously.

Thank you for your cooperaton and assistance.

MIDWIFERY PREPARATION

Please indicate by circling the appropriate number whether or not you have had any midwifery preparation.

1. I have not taken any midwifery education courses or programs, therefore, I am not nor have been a midwife.

   I am (have been) a midwife and I acquired my formal midwifery education.

2. After my nursing education (nurse-midwifery)
3. Before my nursing education (direct entry midwifery)
4. other (please explain) ______________________

____

____

APPENDIX D

The Midwifery Preparation of RNs and RNAs in Ontario

TABLE Di. RESPONSES TO QUESTION 1: HAVE YOU SUCCESSFULLY COMPLETED A MIDWIFERY EDUCATION PROGRAM?

ANSWERS	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
YES	3893	89.6	132	78.6	4025	89.2	5864	89.6	198	78.6	6062	89.2
NO	110	2.5	14	8.3	124	2.7	166	2.5	21	8.3	187	2.7
ADVANCED MATERNAL AND INFANT NURSING COURSE	65	1.5	6	3.6	71	1.6	98	1.5	9	3.6	107	1.6
OTHER	188	4.3	13	7.7	201	4.4	283	4.3	20	7.7	303	4.4
NO RESPONSE	90	2.1	3	1.8	93	2.1	136	2.1	5	1.8	140	2.1
TOTAL	4346	96.3	168	3.7	4514	100.0	6546	96.3	252	3.7	6798	100.0

[1] The numbers and percentages of RNs and RNAs in this table are based on the total group of respondents (n = 4514).

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

TABLE Dii. RESPONSES TO QUESTION 2: IN WHICH COUNTRY DID YOU COMPLETE YOUR BASIC MIDWIFERY EDUCATION?

COUNTRIES	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
UNITED KINGDOM	3010	77.3	37	28.0	3047	75.7	4535	77.3	56	28.0	4590	75.7
WEST INDIES	309	7.9	17	12.9	326	8.1	466	7.9	26	12.9	491	8.1
INDIA	184	4.7	4	3.0	188	4.7	277	4.7	6	3.0	283	4.7
PHILIPPINES	41	1.0	45	34.1	86	2.1	62	1.0	68	34.1	129	2.1
AUSTRALIA	75	1.9	0	0.0	75	1.9	113	1.9	0	0.0	113	1.9
OTHER	197	5.1	29	22.0	226	5.6	297	5.1	44	22.0	340	5.6
NO RESPONSE	77	1.9	0	0.0	77	1.9	116	1.9	0	0.0	116	1.9
TOTAL	3893	96.7	132	3.3	4025	100.0	5864	96.7	198	3.3	6062	100.0

[1] The numbers and percentages of RNs and RNAs in this table are based on the number of respondents who reported having successfully completed a midwifery education program (n = 4025).

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

TABLE Diii. RESPONSES TO QUESTION 3: HOW LONG WAS THE MIDWIFERY PROGRAM?

LENGTH OF PROGRAM	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
LESS THAN SIX MONTHS	10	.3	0	0.0	10	.2	15	.3	0	0.0	15	.2
SIX MONTHS TO ONE YEAR	3278	84.2	27	20.5	3305	82.1	4938	84.2	41	20.5	4979	82.1
MORE THAN ONE YEAR TO TWO YEARS	523	13.4	97	73.5	620	15.4	787	13.4	146	73.5	933	15.4
MORE THAN TWO YEARS	6	.2	8	6.1	14	.3	9	.2	12	6.1	21	.3
NO RESPONSE	76	2.0	0	0.0	76	1.9	115	2.0	0	0.0	115	1.9
TOTAL	3893	96.7	132	3.3	4025	100.0	5864	96.7	198	3.3	6062	100.0

[1] The numbers and percentages of RNs and RNAs in this table are based on the number of respondents who reported having successfully completed a midwifery education program (n = 4025).

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

TABLE Div. RESPONSES TO QUESTION 4: WHAT YEAR DID YOU COMPLETE THIS PROGRAM?

YEAR OF PROGRAM COMPLETION	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
1980-1986	6	.2	0	0.0	6	.1	9	.2	0	0.0	9	.1
1970-1979	668	17.2	24	18.2	692	17.2	1006	17.2	36	18.2	1042	17.2
1960-1969	1886	48.4	81	61.4	1967	48.9	2841	48.4	122	61.4	2963	48.9
BEFORE 1960	1256	[illegible]	26	19.7	1282	31.9	1892	32.3	39	19.7	1931	31.9
NO RESPONSE	77	2.0	1	.8	78	1.9	116	2.0	2	.8	118	1.9
TOTAL	3893	96.7	132	3.3	4025	100.0	5864	96.7	39	3.3	6062	100.0

[1] The numbers and percentages of RNs and RNAs in this table are based on the number of respondents who reported having successfully completed a midwifery education program (n = 4025).

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

TABLE Dv. RESPONSES TO QUESTION 5: UPON COMPLETION OF THE MIDWIFERY PROGRAM DID YOU RECEIVE ONE OF THE FOLLOWING FORMS OF RECOGNITION FROM THE INSTITUTION SPONSORING THE PROGRAM?

EDUCATIONAL CREDENTIAL	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
CERTIFICATE	3122	80.2	83	62.9	3205	79.6	4703	80.2	125	62.9	4828	79.6
DIPLOMA	595	15.3	49	37.1	644	16.0	896	15.3	74	37.1	969	16.0
BACHELOR'S DEGREE	14	.4	0	0.0	14	.3	21	.4	0	0.0	21	.3
MASTER'S DEGREE	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
OTHER	12	.3	0	0.0	12	.3	18	.3	0	0.0	18	.3
NO RESPONSE	150	3.9	0	0.0	150	3.7	226	3.9	0	0.0	226	3.7
TOTAL	3893	96.7	132	3.3	4025	100.0	5864	96.7	198	3.3	6062	100.0

[1] The numbers and percentages of RNs and RNAs in this table are based on the number of respondents who reported having successfully completed a midwifery education program (n = 4025).

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

TABLE Dvi. RESPONSES TO QUESTION 6: WHAT TYPE OF INSTITUTION SPONSORED THE MIDWIFERY PROGRAM?

SPONSOR	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
HOSPITAL	3125	80.3	91	68.9	3216	79.9	4708	80.3	137	68.9	4844	79.9
INDEPENDENT SCHOOL OF MIDWIFERY	406	10.4	23	17.4	429	10.7	612	10.4	35	17.4	646	10.7
UNIVERSITY	108	2.8	2	1.5	110	2.7	163	2.8	3	1.5	166	2.7
COLLEGE	15	.4	2	1.5	17	.4	23	.4	3	1.5	26	.4
OTHER	239	6.1	14	10.6	253	6.3	361	6.1	22	10.6	383	6.3
NO RESPONSE	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	3893	96.7	132	3.3	4025	100.0	5864	96.7	198	3.3	6062	100.0

[1] The numbers and percentages of RNs and RNAs in this table are based on the number of respondents who reported having successfully completed a midwifery education program (n = 4025).

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

TABLE Dvii. RESPONSES TO QUESTION 7: HOW WOULD YOU DESCRIBE THE PROGRAM?

TYPE OF PROGRAM	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
THEORY (CLASSROOM) ONLY	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
CLINICAL EXPERIENCE ONLY	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
COMBINATION	3893	100.0	132	100.0	4025	100.0	5864	100.0	198	100.0	6062	100.0
TOTAL	3893	100.0	132	100.0	4025	100.0	5864	100.0	198	100.0	6062	100.0

[1] The numbers and percentages of RNs and RNAs in this table are based on the number of respondents who reported having successfully completed a midwifery education program (n = 4025).

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

TABLE Dviii. RESPONSES TO QUESTION 9: HAVE YOU TAKEN A MIDWIFERY REFRESHER COURSE?

ANSWER	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
NO	3578	91.9	115	87.1	3693	91.8	5390	91.9	173	87.1	5562	91.8
YES	312	8.0	17	12.9	329	8.2	470	8.0	26	12.9	496	8.2
NO RESPONSE	3	.1	0	0.0	3	.1	5	.1	0	0.0	5	.1
TOTAL	3893	96.7	132	3.3	4025	100.0	5864	96.7	198	3.3	6062	100.0

[1] The numbers and percentages of RNs and RNAs in this table are based on the number of respondents who reported having successfully completed a midwifery education program (n = 4025).

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

TABLE Dix. RESPONSES TO QUESTION 10: FOLLOWING COMPLETION OF YOUR BASIC MIDWIFERY EDUCATION, DID YOU OBTAIN ONE OF THE FOLLOWING FORMS OF GOVERNMENT OR PROFESSIONAL MIDWIFERY CREDENTIAL?

REGULATORY CREDENTIAL	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
NONE	181	4.6	0	0.0	181	4.5	273	4.6	0	0.0	273	4.5
CERTIFICATION	1955	50.2	31	23.5	1986	49.3	2945	50.2	47	23.5	2992	49.4
REGISTRATION	1034	26.6	66	50.0	1100	27.3	1558	26.6	99	50.0	1657	27.3
LICENSURE	322	8.3	17	12.9	339	8.4	485	8.3	26	12.9	511	8.4
OTHER	159	4.1	5	3.8	164	4.1	240	4.1	8	3.8	247	4.1
NO RESPONSE	242	6.2	13	9.8	255	6.3	365	6.2	20	9.8	384	6.3
TOTAL	3893	96.7	132	3.3	4025	100.0	5864	96.7	198	3.3	6062	100.0

[1] The numbers and percentages of RNs and RNAs in this table are based on the number of respondents who reported having successfully completed a midwifery education program (n = 4025).

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

APPENDIX E

The Midwifery Preparation of RNs and RNAs Who Want to Practise Midwifery

TABLE Ei—TABLE Eviii

TABLE Ei. RESPONSES TO QUESTION 1: HAVE YOU SUCCESSFULLY COMPLETED A MIDWIFERY EDUCATION PROGRAM?

ANSWERS	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
YES	510	93.4	57	76.0	567	91.3	768	93.4	86	76.0	854	91.3
NO	2	.4	8	10.7	10	1.6	3	.4	12	10.7	15	1.6
ADVANCED MATERNAL AND INFANT NURSING COURSE	23	4.2	0	0.0	23	3.7	35	4.2	0	0.0	35	3.7
OTHER	8	1.5	9	12.0	17	2.7	12	1.5	14	12.0	26	2.7
NO RESPONSE	3	.5	1	1.3	4	.6	5	.5	2	1.3	6	.6
TOTAL	546	87.9	75	12.1	621	100.0	822	87.9	113	12.1	935	100.0

[1] These are the number and percentage of RN and RNA respondents who answered yes to Question 18 indicating they want to practise midwifery when it is legalized in Ontario.

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

TABLE Eii. RESPONSES TO QUESTION 2: IN WHICH COUNTRY DID YOU COMPLETE YOUR BASIC MIDWIFERY EDUCATION?

COUNTRIES	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
UNITED KINGDOM	329	64.5	18	31.6	347	61.2	496	64.5	27	31.6	523	61.2
WEST INDIES	79	15.5	9	15.8	88	15.5	119	15.5	14	15.8	133	15.5
INDIA	78	15.3	2	3.5	80	14.1	118	15.3	3	3.5	121	14.1
PHILIPPINES	13	2.5	17	29.8	30	5.3	20	2.5	26	29.8	45	5.3
AUSTRALIA	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
OTHER	11	2.2	11	19.3	22	3.9	17	2.2	17	19.3	34	3.9
TOTAL	510	89.9	57	10.1	567	100.0	768	89.9	86	10.1	854	100.0

[1] These are the number and percentage of RN and RNA respondents who answered yes to Question 18 indicating they want to practise midwifery when it is legalized in Ontario and had successfully completed a midwifery education program (n = 567).

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

[3] The number of respondents in each category adds up to more than the totals because of the weighting and rounding processes in the computer analysis.

TABLE Eiii. RESPONSES TO QUESTION 3: HOW LONG WAS THE MIDWIFERY PROGRAM?

LENGTH OF PROGRAM	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
LESS THAN SIX MONTHS	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
SIX MONTHS TO ONE YEAR	403	79.0	10	17.5	413	72.8	607	79.0	15	17.5	622	72.9
MORE THAN ONE YEAR TO TWO YEARS	104	20.4	42	73.7	146	25.7	157	20.4	63	73.7	220	25.7
MORE THAN TWO YEARS	3	.6	5	8.8	8	1.4	5	.6	8	8.8	12	1.4
TOTAL	510	89.9	57	10.1	567	100.0	768	89.9	86	10.1	854	100.0

[1] These are the number and percentage of RN and RNA respondents who answered yes to Question 18 indicating they want to practise midwifery when it is legalized in Ontario and had successfully completed a midwifery education program (n = 567).

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

[3] The number of respondents in each category adds up to more than the totals because of the weighting and rounding processes in the computer analysis.

TABLE Eiv. RESPONSES TO QUESTION 4: WHAT YEAR DID YOU COMPLETE THIS PROGRAM?

YEAR OF PROGRAM COMPLETION	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
1980-1986	2	.4	0	0.0	2	.4	3	.4	0	0.0	3	.4
1970-1979	96	18.8	12	21.1	108	19.0	145	18.8	18	21.1	163	19.0
1960-1969	171	33.5	39	68.4	210	37.0	258	33.5	59	68.4	316	37.0
BEFORE 1960	241	47.3	6	10.5	247	43.6	363	47.3	9	10.5	372	43.6
TOTAL	510	89.9	57	10.1	567	100.0	768	89.9	86	10.1	854	100.0

[1] These are the number and percentage of RN and RNA respondents who answered yes to Question 18 indicating they want to practise midwifery when it is legalized in Ontario and had successfully completed a midwifery education program (n = 567).

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

[3] The number of respondents in each category adds up to more than the totals because of the weighting and rounding processes in the computer analysis.

TABLE Ev. RESPONSES TO QUESTION 5: UPON COMPLETION OF THE MIDWIFERY PROGRAM DID YOU RECEIVE ONE OF THE FOLLOWING FORMS OF RECOGNITION FROM THE INSTITUTION SPONSORING THE PROGRAM?

EDUCATIONAL CREDENTIAL	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[3]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
CERTIFICATE	324	63.5	45	78.9	369	65.1	488	63.5	68	78.9	556	65.1
DIPLOMA	106	20.8	12	21.1	118	20.8	160	20.8	18	21.1	178	20.8
BACHELOR'S DEGREE	3	.6	0	0.0	3	.5	5	.6	0	0.0	5	.5
MASTER'S	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
OTHER	2	.4	0	0.0	2	.4	3	.4	0	0.0	3	.4
NO RESPONSE	75	14.7	0	0.0	75	13.2	113	14.7	0	0.0	113	13.2
TOTAL	510	89.9	57	10.1	567	100.0	768	89.9	86	10.1	854	100.0

[1] These are the number and percentage of RN and RNA respondents who answered yes to Question 18 indicating they want to practise midwifery when it is legalized in Ontario and had successfully completed a midwifery education program (n = 567).

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

[3] The number of respondents in each category adds up to more than the totals because of the weighting and rounding processes in the computer analysis.

TABLE Evi. RESPONSES TO QUESTION 6: WHAT TYPE OF INSTITUTION SPONSORED THE MIDWIFERY PROGRAM?

SPONSOR	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
HOSPITAL	249	48.8	41	71.9	290	51.1	375	48.8	62	71.9	437	51.1
INDEPENDENT SCHOOL OF MIDWIFERY	172	33.7	11	19.3	183	32.3	259	33.7	17	19.3	276	32.3
UNIVERSITY	10	2.0	1	1.8	11	1.9	15	2.0	2	1.8	17	1.9
COLLEGE	1	.2	0	0.0	1	.2	2	.2	0	0.0	2	.2
OTHER	78	15.3	4	7.1	82	14.5	118	15.3	7	7.1	125	14.5
TOTAL	510	89.9	57	10.1	567	100.0	768	89.9	86	10.1	854	100.0

[1] These are the number and percentage of RN and RNA respondents who answered yes to Question 18 indicating they want to practise midwifery when it is legalized in Ontario and had successfully completed a midwifery education program (n = 567).

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

[3] The number of respondents in each category adds up to more than the totals because of the weighting and rounding processes in the computer analysis.

TABLE Evii. RESPONSES TO QUESTION 9: HAVE YOU TAKEN A MIDWIFERY REFRESHER COURSE?

ANSWER	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
NO	504	98.8	52	91.2	556	98.1	759	98.8	78	91.2	837	98.1
YES	4	.8	5	8.8	9	1.6	6	.8	8	8.8	14	1.6
NO RESPONSE	2	.4	0	0.0	2	.4	3	.4	0	0.0	3	.4
TOTAL	510	89.9	57	10.1	567	100.0	768	89.9	86	10.1	854	100.0

TABLE Eviii. RESPONSES TO QUESTION 10: FOLLOWING COMPLETION OF YOUR BASIC MIDWIFERY EDUCATION, DID YOU OBTAIN ONE OF THE FOLLOWING FORMS OF GOVERNMENT OR PROFESSIONAL MIDWIFERY CREDENTIAL?[1]

REGULATORY CREDENTIAL	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
NONE	6	1.2	0	0.0	6	1.1	9	1.2	0	0.0	9	1.1
CERTIFICATION	177	34.7	17	29.8	194	34.2	267	34.7	26	29.8	292	34.2
REGISTRATION	238	46.7	23	40.4	261	46.0	359	46.7	35	40.4	393	46.0
LICENSURE	81	15.9	9	15.8	90	15.9	122	15.9	14	15.8	136	15.9
OTHER	1	.2	3	5.3	4	.7	2	.2	5	5.3	6	.7
NO RESPONSE	7	1.4	5	8.8	12	2.1	11	1.4	8	8.8	18	2.1
TOTAL	510	89.9	57	10.1	567	100.0	768	89.9	86	10.1	854	100.0

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[1] These are the number and percentage of RN and RNA respondents who answered yes to Question 18 indicating they want to practise midwifery when it is legalized in Ontario and had successfully completed a midwifery education program (n = 567).

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

[3] The number of respondents in each category adds up to more than the totals because of the weighting and rounding processes in the computer analysis.

APPENDIX F

The Midwifery Work Experience of RNs and RNAs in Ontario

TABLE Fi—TABLE Fvi

TABLE Fi. RESPONSES TO QUESTION 11: HAVE YOU PRACTISED AS A MIDWIFE ACCORDING TO THE ABOVE DEFINITION?

ANSWER	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
PRACTISED AS A MATERNAL/INFANT NURSE	674	15.5	2	7.1	686	15.2	1015	15.5	18	7.1	1033	15.2
PRACTISED AS A PUBLIC HEALTH NURSE	6	.1	0	0.0	6	.1	9	.1	0	0.0	9	.1
BOTH MATERNAL/ INFANT NURSE AND PUBLIC HEALTH NURSE	160	3.7	0	0.0	160	3.5	241	3.7	0	0.0	241	3.5
OTHER	309	7.1	6	3.6	315	7.0	466	7.1	9	3.6	475	7.0
NO RESPONSE	244	5.6	13	7.7	257	5.7	368	5.6	20	7.7	387	5.7
TOTAL	4346	96.3	168	3.7	4514	100.0	6546	96.3	252	3.7	6798	100.0

[1] The numbers and percentages of RNs and RNAs in this table are based on the total group of respondents (n = 4514).

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

TABLE Fii. RESPONSES TO QUESTION 12: HOW MANY YEARS (TOTAL) HAVE YOU PRACTISED AS A MIDWIFE?

YEARS OF PRACTICE	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
LESS THAN ONE YEAR	530	24.3	12	9.5	542	23.5	798	24.3	18	9.5	816	23.5
ONE TO TWO YEARS	516	23.6	25	19.8	541	23.4	777	23.6	38	19.8	814	23.4
THREE TO FIVE YEARS	563	25.8	34	27.0	597	25.9	848	25.8	51	27.0	899	25.9
MORE THAN FIVE YEARS	412	18.9	49	38.9	461	20.0	621	18.9	74	38.9	694	20.0
NO RESPONSE	161	7.4	6	4.8	167	7.2	243	7.4	9	4.8	252	7.2
TOTAL	2182	94.5	126	5.5	2308	100.0	3287	94.5	189	5.5	3476	100.0

[1] The numbers and percentages of RNs and RNAs in this table are based on the number of respondents who have practised as a midwife according to the given definition (n = 2308).

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

TABLE Fiii. RESPONSES TO QUESTION 13: WHAT YEAR DID YOU LAST PRACTISE AS A MIDWIFE?

INTERVAL OF YEARS SINCE LAST PRACTICE	NUMBER OF YEARS SINCE LAST PRACTICE	RESPONDENTS[1]		REGISTRANT ESTIMATES	
		No.	%	No.	%
1986	0	15	.6	23	.6
1981-1985	1—5	34	1.5	51	1.5
1976-1980	6—10	341	14.8	515	14.8
1966-1975	11—20	736	31.9	1110	31.9
1956-1965	21—30	868	37.6	1310	37.6
BEFORE 1955	Over 30 Years	159	6.9	241	6.9
NO RESPONSE		155	6.7	234	6.7
TOTAL		2308	100.0	3476	100.0

[1] The numbers and percentages of RNs and RNAs in this table are based on the number of respondents who have practised as a midwife according to the given definition (n = 2308).

TABLE Fiv. RESPONSES TO QUESTION 14: WITH YOUR TOTAL MIDWIFERY EXPERIENCE IN MIND, CIRCLE ALL THE FUNCTIONS YOU HAVE PERFORMED THROUGHOUT YOUR MIDWIFERY CAREER?

MIDWIFERY FUNCTIONS	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
ANTEPARTUM CARE	1938	88.8	113	89.7	2051	88.9	2973	88.8	173	89.7	3146	88.9
PRENATAL CLASSES	1477	67.7	95	75.4	1572	68.1	2228	67.7	145	75.4	2373	68.1
INTRAPARTUM CARE *EXCLUDING* DELIVERIES	1671	76.6	86	68.3	1757	76.1	2519	76.6	132	68.3	2651	76.1
INTRAPARTUM CARE *INCLUDING* DELIVERIES	1935	88.7	112	88.9	2047	88.7	2919	88.7	172	88.9	3091	88.7
POSTPARTUM CARE	2012	92.2	114	90.5	2126	92.1	3034	92.2	173	90.5	3207	92.1
FAMILY PLANNING	835	38.3	80	63.5	915	39.6	1261	38.3	122	63.5	1383	39.6
WELL WOMAN HEALTH CARE	1233	56.5	74	58.7	1307	56.6	1860	56.5	114	58.7	1974	56.6
WELL INFANT CARE	1555	71.3	92	73.0	1647	71.4	2346	71.3	141	73.0	2487	71.4
TOTAL[3]	2182	94.5	126	5.5	2308	100.0	3287	94.5	189	5.5	3476	100.0

[1] The number and percentage of RNs and RNAs in this table are based on the number of repondents who have practised as a midwife according to the given definition (n = 2308).

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

[3] Respondents were encouraged to report all the functions they had performed throughout their midwifery career, therefore, the columns add up to more than the reported total numbers and percentages.

TABLE Fv. RESPONSES TO QUESTION 15: IN WHICH OF THE FOLLOWING SETTINGS HAVE YOU PRACTISED AS A MIDWIFE?

SETTINGS	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
HOSPITAL	2027	92.9	92	73.0	2119	91.8	3054	92.9	138	73.0	3192	91.8
HOME	1290	59.1	84	66.7	1374	59.5	1943	59.1	126	66.7	2069	59.5
CLINIC/ COMMUNITY HEALTH CENTRE	583	26.7	44	34.9	627	27.2	878	26.7	66	34.9	944	27.2
OUTPOST HEALTH SERVICE	208	9.5	25	19.8	233	10.1	313	9.5	38	19.8	351	10.1
PHYSICIAN PRIVATE PRACTICE	153	7.0	13	10.3	166	7.2	231	7.0	20	10.3	250	7.2
BIRTHING CENTRE	91	4.2	10	7.9	101	4.4	137	4.2	15	7.9	152	4.4
MIDWIFE PRIVATE PRACTICE	19	0.9	30	23.8	49	2.1	29	0.9	45	23.8	74	2.1
OTHER	154	7.1	2	1.6	156	6.8	232	7.1	3	1.6	235	6.8
TOTAL[3]	2182	94.5	126	5.5	2308	100.0	3287	94.5	189	5.5	3476	100.0

[1] The number and percentage of RNs and RNAs in this table are based on the number of repondents who have practised as a midwife according to the given definition (n = 2308).

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

[3] This table presents the number and percentage of respondents and estimated registrants who practised midwifery in various settings. Since many practised in more than one setting the row and column percentages frequently add up to more than one hundred.

TABLE Fvi. RESPONSES TO QUESTION 16: IN WHICH COUNTRY/COUNTRIES HAVE YOU PRACTISED AS A MIDWIFE?

COUNTRIES	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
UNITED KINGDOM	1151	52.7	30	23.8	1181	51.2	1734	52.7	45	23.8	1779	51.2
WEST INDIES	157	7.2	14	11.1	171	7.4	237	7.2	21	11.1	258	7.4
UNITED KINGDOM AND ANOTHER COUNTRY	225	10.3	4	3.2	229	9.9	339	10.3	7	3.2	346	9.9
CANADA	39	1.8	0	0.0	39	1.7	59	1.8	0	0.0	59	1.7
CANADA AND ANOTHER COUNTRY	233	10.7	3	2.4	236	10.2	352	10.7	5	2.4	357	10.2
INDIA	78	3.6	2	1.6	80	3.5	118	3.6	3	1.6	121	3.5
ICELAND	75	3.4	0	0.0	75	3.2	113	3.4	0	0.0	113	3.3
PHILIPPINES	37	1.7	34	27.0	71	3.1	56	1.7	51	27.0	107	3.1
OTHER	176	8.1	33	26.2	209	9.1	266	8.1	50	26.2	316	9.1
NO RESPONSE	11	.5	6	4.8	17	.7	17	.5	9	4.8	26	.7
TOTAL	2182	94.5	126	5.5	2308	100.0	3287	94.5	189	5.4	3476	100.0

[1] The number and percentage of RNs and RNAs in this table are based on the number of repondents who have practised as a midwife according to the given definition (n = 2308).

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

APPENDIX G

The Midwifery Work Experience of RNs and RNAs Who Want to Practise Midwifery
TABLE Gi—TABLE Gvi

TABLE Gi. RESPONSES TO QUESTION 11: HAVE YOUR PRACTISED AS A MIDWIFE ACCORDING TO THE ABOVE DEFINITION?

ANSWERS	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
YES	49	9.0	61	81.3	110	17.7	74	9.0	92	81.4	165	17.6
NO	174	31.9	6	8.0	180	29.0	262	31.9	9	8.0	271	29.0
PRACTISED AS A MATERNAL/INFANT NURSE	88	16.1	2	2.7	90	14.5	133	16.1	3	2.7	136	14.5
PRACTISED AS A PUBLIC HEALTH NURSE	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
BOTH MATERNAL/ INFANT NURSE & PUBLIC HEALTH NURSE	80	14.7	0	0.0	80	12.9	121	14.7	0	0.0	121	12.9
OTHER	79	14.5	3	4.0	82	13.2	119	14.4	5	4.0	124	13.3
NO RESPONSE	76	13.9	3	4.0	79	12.7	115	13.9	5	4.0	119	12.7
TOTAL	546	87.9	75	12.1	621	100.0	822	87.9	113	12.0	935	100.0

[1] These are the number and percentage of RN and RNA respondents who answered yes to Question 18 indicating they want to practise midwifery when it is legalized in Ontario.

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

[3] The number of respondents in each category adds up to more than the totals because of the weighting and rounding processes in the computer analysis.

TABLE Gii. RESPONSES TO QUESTION 12: HOW MANY YEARS (TOTAL) HAVE YOU PRACTICED AS A MIDWIFE?

YEARS OF PRACTICE	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[3]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
LESS THAN ONE YEAR	4	8.2	4	6.6	8	7.3	6	8.2	6	6.6	12	7.3
ONE TO TWO YEARS	18	36.7	12	19.7	30	27.3	27	36.7	18	19.7	45	27.3
THREE TO FIVE YEARS	11	22.4	22	36.1	33	30.0	17	22.4	33	36.1	50	30.0
MORE THAN FIVE YEARS	14	28.6	23	37.7	37	33.6	21	28.6	35	37.7	56	33.6
NO RESPONSE	2	4.1	0	0.0	2	1.8	3	4.1	0	0.0	3	1.8
TOTAL	49	44.5	61	55.5	110	100.0	74	44.5	92	55.5	165	100.0

[1] These are the number and percentage of RN and RNA respondents who answered yes to Question 18 indicating they want to practise midwifery when it is legalized in Ontario and have practised as midwives (n = 110).

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

[3] The number of respondents in each category adds up to more than the totals because of the weighting and rounding processes in the computer analysis.

TABLE Giii. RESPONSES TO QUESTION 13: WHAT YEAR DID YOU LAST PRACTISE AS A MIDWIFE?

INTERVAL OF YEARS SINCE LAST PRACTICE	NUMBER OF YEARS SINCE LAST PRACTICE	RESPONDENTS[1]		REGISTRANT ESTIMATES	
		No.	%	No.	%
1986	0	2	1.8	3	1.8
1981-1985	1—5	11	10.0	17	10.0
1976-1980	6—10	16	14.5	24	14.5
1966-1975	11—20	60	54.6	90	54.6
1956-1965	21—30	13	11.8	19	11.8
BEFORE 1955	OVER 30 YEARS	8	7.3	12	7.3
TOTAL		110	100.0	165	100.0

[1] These are the number and percentage of RN and RNA respondents who answered yes to Question 18 indicating they want to practise midwifery when it is legalized in Ontario and have practised as midwives (n = 110).

TABLE Giv. RESPONSES TO QUESTION 14: WITH YOUR TOTAL MIDWIFERY EXPERIENCE IN MIND, CIRCLE ALL THE FUNCTIONS YOU HAVE PERFORMED THROUGHOUT YOUR MIDWIFERY CAREER

MIDWIFERY FUNCTIONS	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
ANTEPARTUM CARE	44	89.8	59	96.7	103	93.6	66	89.8	89	96.7	155	93.6
PRENATAL CLASSES	41	83.7	53	86.9	94	85.4	61	83.7	80	86.9	141	85.4
INTRAPARTUM CARE *EXCLUDING* DELIVERIES	30	61.2	46	75.4	76	69.1	45	61.2	69	75.4	114	69.1
INTRAPARTUM CARE *INCLUDING* DELIVERIES	45	91.8	57	93.4	102	92.7	67	91.8	86	93.4	153	92.7
POSTPARTUM CARE	43	87.8	58	95.1	101	91.8	65	87.8	87	95.1	152	91.8
FAMILY PLANNING	42	85.7	46	75.4	88	80.0	63	85.7	69	75.4	132	80.0
WELL WOMAN HEALTH CARE	44	89.8	35	57.4	79	71.8	66	89.8	53	57.4	119	71.8
WELL INFANT CARE	44	89.8	43	87.8	87	79.1	66	89.8	65	87.8	131	79.1
TOTAL[3]	49	44.5	61	55.5	110	100.0	74	44.5	92	55.5	165	100.0

[1] These are the number and percentage of RN and RNA respondents who answered yes to Question 18 indicating they want to practise midwifery when it is legalized in Ontario.

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

[3] Respondents were encouraged to report all the functions they had performed throughout their midwifery career, therefore, the columns add up to more than the reported total numbers and percentages.

TABLE Gv. RESPONSES TO QUESTION 15: IN WHICH OF THE FOLLOWING SETTINGS HAVE YOU PRACTISED AS A MIDWIFE?

SETTINGS	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
HOSPITAL	28	59.6	45	73.8	73	67.6	42	59.9	68	73.8	110	67.6
HOME	31	66.0	46	75.4	77	71.3	47	66.0	69	75.4	116	71.3
CLINIC/ COMMUNITY HEALTH CENTRE	15	31.9	22	36.1	37	34.3	23	31.9	33	36.1	56	34.3
OUTPOST HEALTH SERVICE	20	42.6	10	16.4	30	27.8	30	42.6	15	16.4	45	27.8
PHYSICIAN PRIVATE PRACTICE	0	0.0	9	14.8	9	8.3	0	0.0	14	14.8	14	8.3
BIRTHING CENTRE	7	14.9	6	9.8	13	12.0	11	14.9	9	9.8	20	12.0
MIDWIFE PRIVATE PRACTICE	7	14.9	22	36.1	29	26.9	11	14.9	33	36.1	44	26.9
OTHER	2	4.3	2	3.3	4	3.7	3	4.3	3	3.3	6	3.7
TOTAL	47	43.5	61	56.5	108	100.0	71	43.5	92	56.5	162	100.0

[1] These [illegible] number and percentage of RN and RNA respondents who answered yes to Question 18 indicating they want to practise midwifery when it is legalized in Ontario and have practised as midwives.

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

[3] This table presents the number and percentage of those who practised midwifery in various settings. Since many practised in more than one setting, the row and column percentage frequently add up to more than one hundred. Two missing cases were reported in the analysis of the responses to this question. Hence the discrepancy between the totals 108 and 162 as compared with the totals 110 and 165 reported in other tables in this appendix.

TABLE Gvi. RESPONSES TO QUESTION 16: IN WHICH COUNTRY/COUNTRIES HAVE YOU PRACTISED AS A MIDWIFE?

COUNTRIES	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
UNITED KINGDOM	10	20.4	17	27.9	27	24.5	15	20.4	26	27.9	41	24.5
WEST INDIES	6	12.2	8	13.1	14	12.7	9	12.2	12	13.1	21	12.7
UNITED KINGDOM AND ANOTHER COUNTRY	0	0.0	2	3.2	2	1.8	0	0.0	4	3.2	4	1.8
CANADA	12	24.5	0	0.0	12	10.9	18	24.5	0	0.0	18	10.9
CANADA AND ANOTHER COUNTRY	4	8.2	3	4.9	7	6.4	6	8.2	5	4.9	11	6.4
INDIA	0	0.0	2	3.2	2	1.8	0	0.0	3	3.2	3	1.8
ICELAND	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
PHILIPPINES	13	26.5	15	24.6	28	25.5	20	26.5	23	24.6	42	25.5
OTHER	2	4.1	14	23.0	16	14.5	3	4.1	21	23.0	24	14.5
NO RESPONSE	2	4.1	0	0.0	2	1.8	3	4.1	0	0.0	3	1.8
TOTAL	49	44.5	61	55.5	110	100.0	74	44.5	92	55.5	165	100.0

[1] These are the number and percentage of RN and RNA respondents who answered yes to Question 18 indicating they want to practise midwifery when it is legalized in Ontario and have practised as midwives (n = 110).

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

[3] The number of respondents in each category adds up to more than the totals because of the weighting and rounding processes in the computer analysis.

APPENDIX H

The Practice Preferences of RNs and RNAs Who Want to Practise Midwifery When it is Legalized in Ontario

TABLE Hi — TABLE Hx

TABLE Hi. RESPONSES TO QUESTION 18: WHEN THE PRACTICE OF MIDWIFERY IS LEGALIZED IN ONTARIO, WOULD YOU WANT TO PRACTISE AS A MIDWIFE?[1]

ANSWER	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
YES	546	12.6	75	44.6	621	13.7	822	12.6	113	44.6	935	13.7
MAYBE/DEPENDS	1162	26.7	65	38.7	1227	27.2	1750	26.7	98	38.7	1848	27.2
NO	1931	44.4	18	10.7	1949	43.2	2909	44.4	27	10.7	2936	43.2
DON'T KNOW	329	7.6	8	4.4	337	7.5	496	7.6	12	4.8	508	7.5
NO RESPONSE	378	8.7	2	1.2	380	8.4	570	8.7	3	1.2	573	8.4
TOTAL	4346	96.3	168	3.7	4514	100.0	6546	96.3	252	3.7	6798	100.0

[1] The numbers and percentages of RNs and RNAs in this table are based on the total group of respondents (n = 4514).

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

TABLE Hii. THE OPINIONS OF THE RN AND RNA RESPONDENTS[1] REGARDING SELECTED MIDWIFERY POLICY STATEMENTS.[2]

POLICY STATEMENTS	STRONGLY AGREE		SOMEWHAT AGREE		DON'T KNOW		SOMEWHAT DISAGREE		STRONGLY DISAGREE		NO RESPONSE		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
1. I believe midwifery should be recognized as an independent profession with separate educational programs and its own regulatory agency.														
RNs[3]	278	50.9	108	19.8	1	.2	82	15.0	77	14.1	0	0.0	546	100.0
RNAs	55	73.3	12	16.0	0	0.0	6	8.0	2	2.7	0	0.0	75	100.0
TOTAL	333	53.6	120	19.3	1	.2	88	14.2	19	12.7	0	0.0	621	100.0
2. I believe midwifery should be a nursing specialty requiring specialized preparation following basic nursing education.														
RNs[3]	441	80.8	8	1.5	0	0.0	8	1.5	14	2.6	75	13.7	546	100.0
RNAs	49	65.3	13	17.3	2	2.7	3	4.0	4	5.3	4	5.3	75	100.0
TOTAL	490	78.9	21	3.4	2	.3	11	1.8	18	2.3	79	12.7	621	100.0
3. I believe qualified midwives who are not nurses should be allowed to practise in Ontario.														
RNs[3]	109	20.0	104	19.0	7	1.3	16	2.9	159	29.1	151	27.7	546	100.0
RNAs	37	49.3	15	20.0	12	16.0	5	6.7	2	2.7	4	5.3	75	100.0
TOTAL	146	23.5	119	19.2	19	3.1	21	3.4	161	25.9	155	24.9	621	100.0
4. I believe qualified midwives who are not nurses should be allowed to deliver babies in hospitals.														
RNs[3]	105	19.2	106	19.4	18	3.3	81	14.8	85	15.6	151	27.7	546	100.0
RNAs	33	44.0	14	18.7	9	12.0	7	9.3	6	8.0	6	8.0	75	100.0
TOTAL	138	22.0	120	19.3	27	4.3	88	14.2	91	14.7	157	25.3	621	100.0
5. I believe any qualified midwife should be permitted to conduct home births.														
RNs[3]	336	61.5	20	2.7	4	.7	5	.9	89	16.3	92	16.8	546	100.0
RNAs	43	57.3	8	10.7	6	8.0	6	8.0	12	16.0	0	0.0	75	100.0
TOTAL	379	61.0	28	4.5	10	1.6	11	1.7	101	16.3	92	14.8	621	100.0

[1] These are the number and percentage of the RN and RNA respondents who answered yes to Question 18 indicating they want to practise midwifery when it is legalized in Ontario (n=621).

[2] The registrant estimates may be obtained by multiplying the number of respondents by 1.5.

[3] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

TABLE Hiii. THE PERSONAL PREFERENCES OF THE RN AND RNA RESPONDENTS[1] REGARDING SPECIFIED PRACTICE OPTIONS.[2]

PRACTICE OPTIONS	STRONGLY FAVOUR		SOMEWHAT FAVOUR		UN-DECIDED		SOMEWHAT OPPOSED		STRONGLY OPPOSED		NO RESPONSE		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
1. Independent/private practice with other midwives (group practice).														
RNs[1]	116	21.2	186	34.1	85	15.6	81	14.8	1	.2	77	14.1	546	100.0
RNAs	21	28.0	20	26.7	13	17.3	2	2.7	12	16.0	7	9.3	75	100.0
TOTAL	137	22.1	206	33.2	98	15.8	83	13.4	13	2.1	84	13.5	621	100.0
2. Independent/private practice by yourself (solo practice).														
RNs[1]	4	.7	16	2.9	21	3.8	259	47.4	88	16.1	158	28.9	546	100.0
RNAs	7	9.3	12	16.0	13	17.3	7	9.3	26	34.7	10	13.3	75	100.0
TOTAL	11	1.8	28	4.5	34	5.5	266	42.8	114	18.4	168	27.1	621	100.0
3. Indpendent/private practice with physicians.														
RNs[1]	408	74.7	24	4.4	107	19.6	3	.5	2	.4	2	.4	546	100.0
RNAs	17	22.7	27	36.0	16	21.3	5	6.7	2	2.7	8	10.7	75	100.0
TOTAL	425	68.4	51	8.2	123	19.8	8	1.3	4	0.6	10	1.6	621	100.0
4. Practice with a physician in a doctor's office as an employee.														
RNs[1]	151	27.7	19	3.5	99	18.1	86	15.8	108	19.8	83	15.2	546	100.0
RNAs	30	40.0	18	24.0	14	18.7	3	4.0	4	5.3	6	8.0	75	100.0
TOTAL	181	29.1	37	6.0	123	19.8	89	14.3	112	18.0	89	14.3	621	100.0
5. Practising in a birthing centre as an employee.														
RNs[1]	182	33.3	193	35.3	9	1.6	75	13.7	4	.7	83	15.2	546	100.0
RNAs	37	49.3	16	21.3	13	17.3	2	2.7	3	4.0	4	5.3	75	100.0
TOTAL	219	35.3209	33.7	22	3.5	77	12.4	7	1.1	87	14.0	621	100.0	

TABLE Hiii. THE PERSONAL PREFERENCES OF THE RN AND RNA RESPONDENTS[1] REGARDING SPECIFIED PRACTICE OPTIONS.[2]

PRACTICE OPTIONS	STRONGLY FAVOUR		SOMEWHAT FAVOUR		UN-DECIDED		SOMEWHAT OPPOSED		STRONGLY OPPOSED		NO RESPONSE		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
6. Practising in a clinic or community health facility as an employee.														
RNs[4]	191	35.0	182	33.3	84	15.4	2	.4	5	.9	82	15.0	546	100.0
RNAs	45	60.0	14	18.7	7	9.3	1	1.3	2	2.7	6	8.0	75	100.0
TOTAL	236	38.0	196	31.6	91	14.7	3	.5	7	1.1	88	14.2	621	100.0
7. Working scheduled shifts as an employee in a hospital.														
RNs[4]	169	31.0	184	33.7	90	16.5	8	1.5	13	2.4	82	15.0	546	100.0
RNAs	47	62.7	13	17.3	7	9.3	1	1.3	3	4.0	4	5.3	75	100.0
TOTAL	216	34.8	197	31.7	97	15.6	9	1.4	16	2.6	86	13.8	621	100.0

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[1]. These are the number and percentage of RN and RNA who answered yes to Question 18 indicating they want to practise midwifery when it is legalized in Ontario (n = 621).

[2]. The registrant estimates may be obtained by multiplying the number of respondents by 1.5.

[4] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

TABLE Hiv. RESPONSES TO QUESTION 20: IF YOU WOULD BE INTERESTED IN ONE OF THE ABOVE INDEPENDENT/PRIVATE PRACTICE OPTIONS, HOW MANY CLIENTS DO YOU THINK YOU WOULD WANT TO MANAGE PER YEAR?

NUMBER OF CLIENTS	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
LESS THAN 25 CLIENTS PER YEAR	7	1.3	3	4.0	10	1.6	11	1.3	5	4.0	16	1.6
25 TO 49 CLIENTS PER YEAR	7	1.3	3	4.0	10	1.6	11	1.3	5	4.0	16	1.6
50 TO 99 CLIENTS PER YEAR	89	16.3	6	8.0	95	15.3	134	16.3	9	8.0	143	15.3
MORE THAN 100 CLIENTS PER YEAR	175	32.1	6	8.0	181	29.2	264	32.1	9	8.0	253	29.2
DON'T KNOW	163	29.9	28	37.3	191	30.8	246	29.9	42	37.3	288	30.8
NOT INTERESTED IN INDEPENDENT/ PRIVATE PRACTICE	96	17.6	21	28.0	117	18.8	145	17.6	32	28.0	177	18.8
NO RESPONSE	9	1.6	8	10.7	17	2.7	14	1.6	12	10.7	26	2.7
TOTAL	546	87.9	75	12.1	621	100.0	822	87.9	113	12.1	935	100.0

[1] These are the number and percentage of RN and RNA respondents who answered yes to Question 18 indicating they want to practise midwifery when it is legalized in Ontario (n=621).

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

TABLE Hv. RESPONSES TO QUESTION 21: WOULD YOU BE WILLING TO TAKE A REFRESHER COURSE (THAT MIGHT BE 3-6 MONTHS DURATION) IN ORDER TO PRACTISE AS A QUALIFIED MIDWIFE?

ANSWERS	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
YES	389	71.2	66	88.0	455	73.3	586	71.2	99	88.0	685	73.3
MAYBE/DEPENDS	79	14.5	7	9.3	86	13.8	119	14.5	11	9.3	130	13.8
NO	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
DON'T KNOW	76	13.9	2	2.7	78	12.6	115	13.9	3	2.7	118	12.6
NO RESPONSE	2	.4	0	0.0	2	.3	3	.4	0	0.0	3	.3
TOTAL	546	87.9	75	12.1	621	100.0	822	87.9	113	12.1	935	100.0

[1] These are the number and percentage of RN and RNA respondents who answered yes to Question 18 indicating they want to practise midwifery when it is legalized in Ontario (n=621).

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

TABLE Hvi. THE PERSONAL PREFERENCES OF THE RN AND RNA RESPONDENTS[1] REGARDING METHODS OF PAYMENT.[2]

METHODS OF PAYMENT	STRONGLY PREFER		SOMEWHAT PREFER		UN-DECIDED		SOMEWHAT OPPOSE		STRONGLY OPPOSE		NO RESPONSE		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
1. SALARY														
RNs[4]	271	49.6	86	15.8	8	1.5	0	0.0	11	2.0	170	31.1	546	100.0
RNAs	55	73.3	6	8.0	6	8.0	0	0.0	2	2.7	6	8.0	75	100.0
TOTAL	326	52.5	92	14.8	14	2.3	0	0.0	13	2.1	176	28.3	621	100.0
2. FEE FOR SERVICE PAID DIRECTLY BY CLIENTS														
RNs[4]	10	1.8	16	2.9	18	3.3	10	1.8	83	15.2	409	74.9	546	100.0
RNAS	7	9.3	8	10.7	12	16.0	10	13.3	9	12.0	29	38.7	75	100.0
TOTAL	17	2.7	24	3.9	30	4.8	20	3.2	92	14.8	438	70.5	621	100.0
3. FEE FOR SERVICE COVERED BY OHIP														
RNs[4]	188	34.4	25	4.6	84	15.4	0	0.0	2	.4	247	45.2	546	100.0
RNA	24	32.0	12	16.0	11	14.7	0	0.0	3	4.0	25	33.3	75	100.0
TOTAL	212	34.1	37	6.0	95	15.3	0	0.0	5	.8	272	43.8	621	100.0

[1] These are the number and percentage of RN and RNA respondents who answered yes to Question 18 indicating they want to practise midwifery when it is legalized in Ontario (n=621).

[2] The registrant estimates may be obtained by multiplying the number of respondents by 1.5.

[4] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

TABLE Hvii. RESPONSE TO QUESTION 23: WHERE DO YOU WANT TO PRACTISE MIDWIFERY?

ANSWERS	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
CURRENT RESIDENCE	527	96.5	58	77.3	585	94.2	794	96.5	87	77.3	881	94.2
OTHER	14	2.6	5	6.7	19	3.1	21	2.6	8	6.7	29	3.1
NO RESPONSE	5	.9	12	16.0	17	2.7	8	.9	18	16.0	26	2.7
TOTAL	546	87.9	75	12.1	621	100.0	822	87.9	113	12.1	935	100.0

[1] These are the number and percentage of RN and RNA respondents who answered yes to Question 18 indicating they want to practise midwifery when it is legalized in Ontario (n=621).

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

TABLE Hviii. RESPONSES TO QUESTION 24: WHAT DO YOU CONSIDER THE APPROPRIATE BASIC EDUCATIONAL PROGRAM FOR A BEGINNING (ENTRY LEVEL) MIDWIFE WHO IS A NURSE?

ANSWER	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
POST-RN BACC. DEGREE PROGRAM OFFERED BY A A UNIVERSITY OR RYERSON	21	3.8	12	16.0	33	5.3	32	3.8	18	16.0	50	5.3
MASTER'S DEGREE PROGRAM OFFERED BY A UNIVERSITY	9	1.6	4	5.3	13	2.1	14	1.6	6	5.3	20	2.1
POST-BASIC CERTIFICATE OFFERED BY A C.A.A.T.	186	34.1	47	62.7	233	37.5	280	34.1	71	62.7	351	37.5
POST-BASIC CERTIFICATE OFFERED BY A UNVERSITY OR RYERSON	201	36.8	28	37.3	229	36.9	303	36.8	42	37.3	345	36.9
A FORMAL APPRENTICESHIP PROGRAM	121	22.2	34	45.3	155	25.0	182	22.2	51	45.3	233	25.0
OTHER	85	15.6	10	13.3	95	15.3	128	15.6	15	13.3	143	15.3
TOTAL[3]	546	87.9	75	12.1	621	100.0	822	87.9	113	12.1	935	100.0

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[1] These are the number and percentage of RN and RNA respondents who answered yes to Question 18 indicating they want to practise midwifery when it is legalized in Ontario (n=621).

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

[3] Since respondents were encouraged to indicate as many options as they thought appropriate, the columns add up to more than the reported total numbers and percentages.

TABLE Hix. RESPONSE TO QUESTION 25: WHAT DO YOU CONSIDER THE APPROPRIATE BASIC EDUCATIONAL PREPARATION FOR A BEGINNING (ENTRY LEVEL) MIDWIFE WHO IS NOT A NURSE?

ANSWER	RESPONDENTS[1]						REGISTRANT ESTIMATES					
	RN[2]		RNA		TOTAL		RN[2]		RNA		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
DIPLOMA PROGRAM OFFERED BY A C.A.A.T.	142	26.0	58	77.3	200	32.2	214	26.0	87	77.3	301	32.2
BACC. DEGREE PROGRAM OFFERED BY A UNIVERSITY OR RYERSON	96	17.6	9	12.0	105	16.9	145	17.6	14	12.0	159	16.9
MASTER'S DEGREE OFFERED BY A UNIVERSITY	8	1.5	2	2.7	10	1.6	12	1.5	3	2.7	15	1.6
A FORMAL APPRENTICESHIP PROGRAM	40	7.3	27	36.0	67	10.8	60	7.3	41	36.0	101	10.8
OTHER	79	14.5	9	12.0	88	14.2	119	14.5	14	12.0	133	14.2
NURSING AS AN OPTION	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
NURSING REQUIRED	77	14.1	0	0.0	77	12.4	116	14.1	0	0.0	116	12.4
TOTAL[3]	546	87.9	75	12.1	621	100.0	822	87.9	113	12.1	935	100.0

[1] These are the number and percentage of RN and RNA respondents who answered yes to to Question 18 indicating they want to practise midwifery when it is legalized in Ontario (n=621).

[2] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

[3] Since respondents were encourgaed to indicate as many (few) options as they thought appropriate, the columns add up to more than (less than) the reported total numbers and percentages.

TABLE Hx. RESPONSES TO QUESTION 26: INDICATE WHETHER OR NOT YOU BELIEVE MIDWIVES SHOULD BE TRAINED AND PERMITTED TO PERFORM THE FOLLOWING PROCEDURES.[1],[2]

PROCEDURES	RNs[3]				RNAs			
	SHOULD		SHOULD NOT		SHOULD		SHOULD NOT	
	No.	%	No.	%	No.	%	No.	%
1. USE VACUUM EXTRACTOR	12	2.2	444	81.3	10	13.3	55	73.3
2. USE FORCEPS	20	3.7	445	81.5	13	17.3	53	70.7
3. PERFORM EPISIOTOMY	461	84.4	7	1.3	57	76.0	11	14.7
4. REPAIR EPISIOTOMY OR SKIN LACERATION	370	67.8	97	17.8	60	80.0	6	8.0
5. CONDUCT INITIAL ASSESSMENT OF NEWBORN	393	72.0	75	13.7	65	86.7	7	9.3
6. INTUBATE NEWBORN	126	23.1	341	62.5	37	49.3	30	40.0
7. PERFORM AMNIOTOMY	109	20.0	262	48.0	26	34.7	35	46.7
8. ADMINISTER LOCAL ANESTHETIC	369	67.6	92	16.8	51	68.0	18	24.0
9. ORDER COMMON DIAGNOSTIC PROCEDURES	374	68.5	93	17.0	52	69.3	12	16.0
10. PRESCRIBE COMMON MEDICATIONS	370	67.8	97	17.8	49	65.3	18	24.0

[1] These are the number and percentage of RN and RNA respondents who answered yes to Question 18 indicating they want to practise midwifery when it is legalized in Ontario (n=621).

[2] The registrant estimates may be obtained by multiplying the number of respondents by 1.5.

[3] The number of RNs may include the actual number of respondents from the RN direct entry and RN other subgroups, as well as the weighted number of respondents from the sample of the RN nurse-midwife subgroup.

APPENDIX 4

Ontario Antenatal Record

ONTARIO
ANTENATAL RECORD 1

HOSPITAL ____________________

PRESS HARD
THIS FORM IS IN TRIPLICATE

PATIENT'S NAME

ADDRESS

PHONE# HOME

DATE OF BIRTH   AGE   EDUC. LEVEL   MAR. STATUS

OCCUPATION   PHONE# WORK

FATHER'S NAME   AGE   OCC.

DOCTOR FAMILY PHYS.	OBS. CARE	BABY CARE	INSURANCE OHIP#

MENSTRUAL HISTORY

LMP (date)   CERTAIN: ☐ YES ☐ NO

CYCLE   DURATION

CONTRACEPTIVES

TYPE: DURATION:

LAST USED:

FAMILY SITUATION

GRAVIDA	TERM	PREM	AB.	LIVE	MULTI PREG

E.D.C.

Dates

Size

[illegible]

HISTORY OF PREGNANCY	YES	NO
BLEEDING		
VOMITING		
PYREXIA		
SMOKING (cigs/day)		
ALCOHOL		
RADIATION		

WHITE - INFANTS CHART

No.	Year	Sex	Gest. Age (wks.)	Birth Wt. (Kg.)	Dur. of Labour	Place of Birth	Type of Delivery	COMMENTS: RE - Pregnancy, Perinatal Death, Abnormality, etc.

PINK - DOCTOR'S COPY

SIGNIFICANT MEDICAL HISTORY

	YES	NO	COMMENTS
KIDNEY DIS.			
HEART DIS.			
HYPERTENSION			
DIABETES			
INFECTIONS			
THYROID DIS.			
TRANSFUSIONS			
OPERATIONS			
OTHER			

FAMILY HISTORY

	YES	NO	COMMENTS
HYPERTENSION			
DIABETES			
HEART DIS.			
MULTIPLE BIRTH			
MALFORMATION			
GENETIC DIS.			
EARLY ONSET DEAFNESS			
OTHER			

ALLERGIES

NUTRITION ASSESSMENT

	YES	NO
MILK PRODUCTS		
BREADS & CEREALS		
FRUITS & VEGETABLES		
PROTEIN SOURCES		

CANARY - MOTHER'S CHART
FORWARD TO HOSPITAL

HEIGHT   PRE-PREGNANCY WEIGHT   PRESENT WEIGHT   B.P.

CHECK (✓) IF NORMAL

HEAD NECK THYROID	☐	VAGINA	☐
ENT.	☐	CERVIX	☐
TEETH	☐	UTERUS	☐
CHEST	☐	ADNEXA	☐
BREASTS	☐	EXTREMITIES	☐
HEART VASC. SYST.	☐	VARICOSITIES	☐
ABDOMEN	☐	NEUROLOGICAL	☐
VULVA	☐	CYTOLOGY	☐

PELVIC ARCHITECTURE

OTHER:

REMARKS (detail abnormal findings)

DISCUSSION TOPICS
- SMOKING
- ALCOHOL
- DRUG USE
- WORK PLANS
- EXERCISE
- COITUS
- PRENATAL CLASSES
- DENTAL CARE

374-64E (85/12)

PHYSICIAN'S SIGNATURE

DATE THIS ATTENDANCE

RISK GRADE

ONTARIO
ANTENATAL RECORD 2

PRESS HARD
THIS FORM IS IN TRIPLICATE

PATIENT'S NAME ....

ADDRESS ....

DOCTORS ....

D M Y

D M Y

QUICKENING D M Y

DATE	WT. (lb./kg.)	CUM. WT. GAIN (lb./kg.)	G-AGE WK.	S-F HT	PRESN. POSN.	FH	URINE			BP	RISK GRADE	LAB	COMMENTS: (OTHER LAB, MEDICATIONS, ETC.)
							PR	GL	AC				

WHITE - INFANT'S CHART

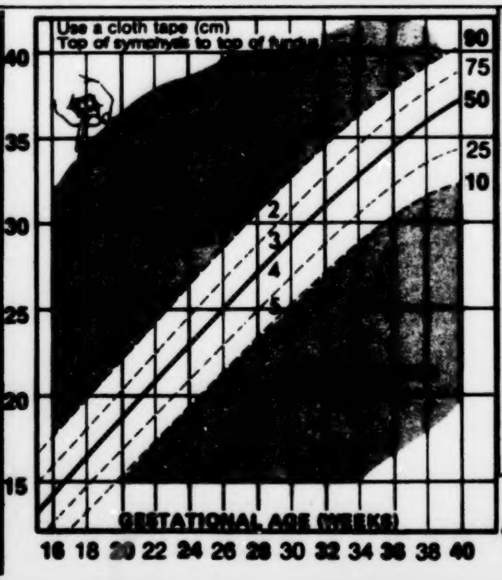
PINK - DOCTOR'S COPY

CANARY - MOTHER'S CHART
FORWARD TO HOSPITAL

375-84E (85/12)

ADDITIONAL COMMENTS:

☐



◀ MEASURE SYMPHYSIS-FUNDUS HEIGHT AT EACH ANTENATAL VISIT AND RECORD ON GRAPH OPPOSITE.

ULTRASOUND AND ABNORMAL LABORATORY RESULTS

PUBLIC HEALTH NURSE

DIETICIAN

SOCIAL WORKER

NUTRITION
DIET
REST
TRAVEL
PREM. LABOUR
BREAST CARE
ANAES MED.
TYPE OF DELIVERY
FATHER AT DELIVERY
BREAST FEEDING
ROOM-IN
CIRCUMCISION
EARLY DISCHARGE
CAR SAFETY
OBSTETRICIAN
PAEDIATRICIAN

PHYSICIAN'S SIGNATURE

APPENDIX 5

Guidelines for Pregnancy Hygiene and Perinatal Assistance

March 1985

DANISH NATIONAL BOARD OF HEALTH

(Unofficial Translation from Danish)

Introduction

Act No. 282 concerning pregnancy hygiene and perinatal assistance dated 7 June 1972 (cf. legislative notice No. 431 dated 3 September 1975 and subsequent amendments), pregnant women are entitled to five free preventive health examinations by a physician, whereof three during pregnancy, and to a number of free health examinations by a midwife. Women have the right to free obstetric assistance at a hospital or other institution and are also entitled to free midwifery assistance in the home.

The law requires the regional municipalities, as well as the Copenhagen and Frederiksberg municipalities, to provide these services at no charge and places on them the full responsibility of organizing the preventive examinations and obstetric services.

Guidelines for the performance of preventive examinations are set by the National Board of Health, including the number of examinations by the midwife. The number of examinations by a midwife during pregnancy has been set at not less than five. In addition, the midwife will make two housecalls during the postnatal confinement.

The examination period covers the pregnancy, birth and confinement periods. It is natural to regard this sequence as a connected process and the guidelines therefore provide the professional framework for the health care delivery system's collective efforts in terms of pregnancy hygiene, obstetric assistance, and postnatal care, including interaction between professional groups from the health care delivery system and the social welfare system.

The present guidelines discuss the interdisciplinary coordination of each step in the examination and training program and also describe the chronology of the program as a consolidated entity. The discussion includes tasks prescribed under midwifery legislation and laws defining the health visitor and visiting nurse system.

The word hygiene is of Greek origin and means the study of everything that promotes health and prevents disease.

Purpose

The purpose of the collective effort by the health care delivery system in providing pregnancy hygiene, obstetric assistance, and postnatal care is to assist and support the woman and her family during the entire process in such a way that birth can take place with maximum safety and peace of mind for the woman, the child, and other family members.

Strong emphasis is therefore placed on preventive measures necessary to ensure the welfare of the entire family during and after pregnancy, and to provide the best possible circumstances for the infant's development.

The purpose of the pregnancy examination program and perinatal assistance can be defined in the following points:

- Preserving the life and health of mother and child during pregnancy, birth, and confinement.
- Establishing secure conditions during pregnancy, birth, and confinement through counselling and practice advice, and by familiarizing the expectant mother with the place of delivery, and its personnel and organization.
- Delivery at term of a well-developed, viable, and well-shaped child of normal birth weight; that is, the aim is to prevent foetal injury and death, injury at birth, premature delivery, and the birth of infants with sub-normal birth weight.
- Optimizing the treatment of any condition or complication affecting the mother or infant.

The guidelines have been developed on the premise that:

- Pregnancy, birth, and confinement constitute a continuous, natural process.
- The woman should have as much influence as possible on her pregnancy and delivery and take part in decisions concerning the place of delivery and the use of equipment.
- The place of delivery is chosen with regard to maximum safety and security and the necessary contact and confidence are established with its personnel.
- Pregnancy check-ups and perinatal assistance are arranged to ensure the expectant mother continuing support by a professional team, while her family practitioner acts as coordinator. The objective should also be to offer the expectant mother preventive health examinations by one midwife, or a small team of midwives, who will come to know her well. It is appropriate to arrange the midwives' obstetric duties in such a way that one of the midwives from the group is present at delivery whenever possible.
- Interdisciplinary support, for example, by a social counsellor, case officer, or physiotherapist, is called upon where necessary.

Overview of the timing of preventive examinations during normal pregnancy and postpartum, including visits by midwife during confinement, visits by health visitors during and after delivery, visits by home care nurses in cases of outpatient or home delivery, and the preparations for delivery and parenthood during and after pregnancy. Brackets around certain numbers indicate those weeks of pregnancy where empirically the need is greatest for the expectant mother to be seen by a midwife.

Organization

The preventive program includes individual health examinations, information and counselling, and group training and exercise sessions.

The overview diagram shows the timing of preventive health examinations during normal pregnancy and delivery.

The expectant mother is examined three times during pregnancy by her own physician. The first of these examinations should take place as early as possible in the pregnancy. It may take place following an earlier consultation where pregnancy was diagnosed, or at the request of a woman who has diagnosed herself as pregnant. During this first examination, the physician will refer the woman for her initial check-up by a midwife (usually in the 12th week of pregnancy).

If the physician deems an early obstetric evaluation of the pregnancy to be desirable, the woman is immediately referred to the outpatient clinic of an obstetrics department, or for consultation to an obstetrician at the out-patient clinic in the obstetrics department at the intended place of delivery.

The expectant mother is also offered a minimum of five check-ups during pregnancy by a midwife, as required.

When out-patient or home delivery is planned, one of the midwife examinations is carried out at the end of pregnancy as a home visit.

During confinement, two visits by the midwife are offered, irrespective of whether birth took place in hospital with postpartum confinement, at another maternity clinic, in an out-patient setting with home confinement, or by home delivery.

Any woman who so desires should have access to an examination by an obstetrician, preferably during weeks 16-18, either at the out-patient clinic of an obstetrics department, or by a visiting specialist from the local out-patient clinic of the obstetrics department at the intended place of delivery. One of the early check-ups by a midwife can be combined with such examination at the local maternity clinic.

The woman must be offered supplementary examinations by her own physician, midwife, or specialist at an obstetric out-patient, or at the intended place of delivery, should the progress of her pregnancy so require. The midwife may also make home visits to pregnant women with special needs.

The health visitor service in the woman's home community may include offers of home visits by a health visitor.

The question of selecting the place of delivery should be discussed with the woman during initial examinations by both physician and midwife. However, the delivery venue can be changed at any time during the pregnancy.

Preventive Health Examinations

Preventive health examinations during pregnancy are conducted by the woman's own physician, midwife or — after referral — by a specialist obstetrician, either at the obstetrics department out-patient clinic or at another maternity out-patient clinic.

Health examinations include a careful case history, review of the woman's state of health and of her, and her family's, social and financial circumstances as well as a thorough physical examination.

During examinations there will be a need for counselling regarding the woman's lifestyle, including her work, diet, use of stimulants, etc. Usually there will be a need to discuss mental, social or work-related problems several times during the pregnancy, including the woman's expectations of, or concerns about, the impending delivery.

It will also be necessary to discuss breast feeding several times during pregnancy to enable the woman and her family to understand its nutritional, emotional, and social value and help her prepare for the task mentally and physically.

Alternative means of infant feeding must naturally also be discussed if required in the individual case.

Throughout the process the woman must be assured of a high level of information and her own desires must be considered and discussed.

The woman and her family should be encouraged to contribute actively to optimizing the course of her pregnancy and delivery and to benefit from the public resources offered, including the choice of delivery venues.

At each health examination during pregnancy, the physician's or midwife's overall assessment of the woman's physical and mental state of health in relation to her social circumstances is critical to the continued planning of examinations, therapies, and other arrangements concerning her pregnancy, and for counselling to select the venue of delivery.

Relief and Bed Rest During Pregnancy

If conditions necessitating relief or bedrest during pregnancy should arise, the woman should be advised as to possibilities for practical assistance in the home (home nursing/domestic assistance). She should be informed that home visits by a midwife are available.

In cases where relief and bedrest at home pose an alternative to hospitalization, or are required in conjunction with hospitalization, the midwife should attend the woman in her home after consultation with the hospital department and/or the family practitioner.

Collaboration Between Physician, Midwife and Medical Staff at the Maternity Hospital, etc.

To meet the objectives of pregnancy examinations and perinatal assistance, the participation of several professional groups, including non-medical personnel, is often necessary. Key persons include the woman's own physician, the midwife who may offer consultations outside the hospital but who is nevertheless associated with the place of delivery, physicians at the maternity hospital and, where required, specialist obstetricians.

The family practitioner, who frequently has known the woman and her family prior to her pregnancy, represents the need for continuity throughout the process of pregnancy, delivery, confinement and the infant's development. He or she undertakes the preventive examinations of children aged 0-6 years.

The family practitioner is the key individual at the beginning of pregnancy in respect of diagnosis and the referral to midwife or specialist based on the initial health examination.

The midwife is the professional in closest contact with the pregnant woman and is the key professional during delivery.

The responsibility for calling upon other professional groups thus rests with the family practitioner and the midwife. Effective collaboration must be established to ensure the woman of the best possible benefits of the preventive care and to avoid activities that are poorly coordinated and stressful.

A prerequisite is that each professional group is informed of the activities of other professional groups in order to prevent unnecessary examinations and conflicting advice. This interdisciplinary information is ensured through the ambulant case records, which therefore must be carefully maintained. Additional coordination of activities is also frequently required through personal contact.

Out-patient or home delivery requires that the efforts of midwife, home nurse, and health visitor are coordinated during confinement.

Cooperation between the woman's own physician and the midwife can be further improved by organizing the physician/midwifery services so that a certain group of physicians collaborate with an identified midwife, or group of midwives. Midwife examinations should ideally take place close to home in order to provide easy access for the expectant mother. It may be expedient to locate the midwife's office(s) in a medical group practice with other facilities that are also utilized in training programs for delivery and parenthood.

Preparations for Delivery and Parenthood

Necessary medical advice on pregnancy is provided to the woman by her physician and midwife. To supplement this counselling, a considerable portion of the collective information and counselling activities should be given during formal group training sessions to prepare for delivery and parenthood.

It should be noted that about 50% of the expectant mothers today have no personal experience of pregnancy or birth. Many pregnant women will furthermore have less opportunity than previously to acquire such knowledge from other women, because of the low birth rate.

The purpose of training is to provide parents with knowledge of the course of pregnancy, delivery, rest during confinement, the neonatal period, and changes in their family circumstances.

Courses should follow current principles of health instruction. They should not be restricted to theory but should be organized to allow participants liberal opportunity to exchange experiences among themselves and with instructors. Courses should provide information on the assistance offered by the health and social welfare systems to the pregnant woman and her family and stimulate them to participate actively during pregnancy, delivery, and the postnatal period. Courses should include relaxation and strength-building exercises (obstetric physiotherapy) in order to prepare the woman physically for delivery.

Practical demonstration of obstetric equipment and instruments is a prerequisite to the woman's participation in selecting the venue and equipment for delivery.

Responsibility for delivery and parenthood training should rest with the midwifery centre. One midwife should preferably conduct all training sessions. In addition to the midwife and physiotherapist, other professionals (such as physicians, health visitors, relaxation instructors, psychologists, social workers) should provide input as instructors. Adult education associations can assist with the practical arrangements.

Delivery and parenthood preparation should start early in pregnancy, shortly after the first examination by the midwife.

Privately arranged delivery and parenthood preparation courses are in fact held in many places, sometimes with support under Legislative Notice #329 dated 11 July 1983 concerning recreational education, etc. These courses provide a useful supplement to those arranged by the midwifery centres.

Delivery Environment

Several elements are critical to the woman's sense of security during delivery:

- Selecting her own delivery venue
- Her knowledge (or prior experience) of childbirth
- The husband's presence and the woman's contact with him (or other relative) during the procedure
- Confidence in the personnel's qualifications and abilities in obstetrics
- The woman's contact with personnel, especially in terms of her knowledge and confidence in the midwife, who preferably should not be replaced during the procedure; and
- A positive attitude towards the use of identified equipment and procedures, if required.

Improving the Delivery Environment

The personnel have many opportunities to create a good delivery environment and recent years have seen considerable improvement in the psychological and physical delivery parameters.

Extraneous noise, including irrelevant staff conversations, should be avoided, also outside the delivery room. Special care should be taken to avoid noise disturbance when several persons are attending the delivery for training purposes. Generally, the number of persons present at delivery should be minimized.

Lighting in the delivery room should be subdued as far as safety permits.

Delivery Venue

The woman should be free to choose among the following venues:

1. Obstetrics department
2. Delivery ward in surgical department (where available) — optionally as out-patient
3. Maternity clinic with delivery room (where available) — optionally as out-patient
4. At home

Obstetrics Department

Patients are referred under local guidelines when the mother is at special risk, or paediatric assistance is required. Whenever birth complications, including prematurity, are expected, delivery should take place in the obstetrics department of hospitals offering neonatology or paediatrics departments with specialists on call, or at other locations where adequate paediatric service during and after parturition has been otherwise arranged so that the child at risk can be observed and treated immediately after birth. Women expecting a normal delivery may give birth in an obstetrics department.

As in other venues, a delivery proceeding is spontaneously supervised by the midwife.

Surgical Department (Delivery Ward)

Deliveries in a surgical department (delivery ward) are supervised by a midwife with equipment and instruments at her disposal, not available to her during home delivery. At all in-hospital deliveries the facilities to give qualified medical assistance to the infant must be assured. However, surgical departments are unable to offer specialist obstetricians on call at all hours and only when a normal delivery is expected should a woman be referred to such department. The department must have a 24-hour duty roster in anaesthesiology and surgery, thus allowing procedures such as a caesarean section if they are necessitated by unforeseen complications. Some hospitals routinely submit all children to a paediatric examination before sending them home.

Maternity Clinic with Delivery Room (ABC Facility: Alternative Birth Care)

A midwife normally supervises delivery in the ABC facility without a physician present. The ABC facility functions as "home delivery" in a specialist department.

The facility should be located in the same building as the specialist department, preferably in close proximity. However, the institutional appearance is avoided by furnishing the premises to simulate domestic conditions wherever possible. In case of complications, immediate transfer is made to the specialist department.

Out-Patient Delivery

Out-patient delivery should be offered at all hospital delivery facilities when a normal birth is anticipated, if the woman so wishes. Should complications arise, or other circumstances make it advisable, the woman is offered to remain in the hospital maternity ward, or possibly a transfer to the confinement ward at another hospital.

When out-patient or home delivery is being planned, the woman should be advised by family physician and midwife of the practical arrangements for confinement at home and of the possibility to receive care and practical help from the municipal, social, and health administrations. A home care nurse or health visitor is informed of the expected birth date. This is confirmed to them and to the woman's own physician after delivery by the midwife.

Home Birth

Physicians and midwives are responsible for advising women of the option of a home delivery.

Home birth offers fewer opportunities than hospital birth for assistance in the event of complications. Physicians and midwives must therefore not recommend home delivery when special risks are present.

When home delivery is selected, the woman must be thoroughly advised of available care and other assistance during her confinement. During home visits the midwife must counsel on necessary practical arrangements in the home. Ideally the woman should be assisted at birth by a midwife she knows, and must be well informed on how to reach a midwife from the group known to her from her pregnancy examinations. She must also be informed that transfer to hospital may become necessary during birth.

If desired by the woman, the midwife, or midwife centre should make arrangements in good time with the woman's own physician, or another physician with obstetric experience, for medical assistance during birth. Note that physicians' groups offering assistance at home births have been organized at many locations.

Home Confinement

Confinement after an out-patient birth or home birth takes place at home. This means that counselling, care, and practical help normally provided by the hospital department must instead be provided by the midwife during confinement visits and by health visitors, home care nurses, or possibly domestic assistants.

Medical Examinations Postpartum

A woman is offered up to two medical examinations postpartum by her own physician. The first of these applies to women having undergone out-patient or home delivery and takes place the first week postpartum. The second examination applies to all mothers and takes place week nine postpartum (National Board of Health, 26 March 1985, Soren K. Sorensen/Ohleschlaeger).

Guidelines

Guidelines concerning:

1. Health examinations by general practitioner
2. Examinations by specialist obstetrician
3. Health examinations by midwife
4. Preparations for delivery and parenthood
5. Perinatal examinations and procedures
6. Confinement period
7. Medical examinations postpartum

1. Health Examinations by General Practitioner

The general practitioner's task is to prevent, diagnose, and treat conditions threatening the satisfactory outcome of pregnancy, and to refer patients to an obstetrics department where necessary. With his or her knowledge of the expectant mother and her circumstances, the practicing physician is especially well placed to give assistance in health instruction and social medicine.

In terms of establishing secure conditions, the family practitioner provides continuity throughout the process and has the best opportunity of providing personalized, continuing counselling and guidance. This places the family physician in the role of coordinator, responsible for referrals to obstetrics or surgery departments and to the social welfare and health administrations.

A woman will frequently want to have her physician confirm her pregnancy without having made an appointment for her initial thorough medical examination. When diagnosing pregnancy it should be determined whether hereditary disease in the family would necessitate early referral for genetic counselling. It is also important to determine whether the woman is exposed to teratogenic effects at work, which might necessitate immediate sick leave or relocation. At this initial consultation, any use of medication should also be evaluated. Special care should be taken to elicit any drug or alcohol abuse requiring special therapy and necessitating early referral to a maternity clinic with experience in this therapeutic area. An appointment for the initial health examination should be made for weeks 8 to 12.

First Medical Examination

At this time a thorough case history is obtained, eliciting information on relevant gynaecological/obstetric conditions and any hereditary predispositions. Unless previously determined, it should now be clarified whether the woman is exposed to teratogenic effects.

The woman's social circumstances (work, home, and finances) should be thoroughly clarified and any need for social welfare assistance determined. It is also essential to know her family circumstances, including her relationship to the child's father. The possible need for special efforts to prevent family problems should be assessed. At this early time, it is often expedient to discuss the care arrangements for the new child.

The progress of the pregnancy from the time of last menstruation to the examination is charted. A thorough, objective examination is carried out, including height, weight, and blood pressure measurements. General condition is assessed, breasts examined and varices and oedemas investigated.

A blood sample is obtained for serodiagnostic tests for syphilis, Rhesus and blood type, and antibodies. The sample is sent to the State Serum Institute, starting 1 June 1985. Urine is tested for protein and glucose. A urine specimen is cultured for asymptomatic bacteria.

During the gynaecological examination, uterus size is assessed relative to the presumed time of conception. The pelvic condition is evaluated.

Based on the physician's knowledge of the woman, she is counselled on appropriate lifestyle, especially in terms of diet, tobacco, alcohol, medication, sex life, sports, and working conditions. General information on pregnancy is provided and the woman encouraged to participate, perhaps with her husband, in preparing for delivery and parenthood later in the pregnancy.

Finally, the choice of delivery location is discussed in light of this first evaluation. Further examinations are planned with the expectant mother. The need for early ultrasound examination is determined, particularly if the date of conception is uncertain (irregular cycles, pregnancy arising shortly after discontinuing oral contraception, lack of correlation between uterus size and menostasis). A decision is made whether to test the amniotic fluid.

Pregnancy records and ambulatory patient records are carefully completed. These records must especially document the outcome of previous pregnancies, particularly in terms of risk factors and social circumstances. If a risk of abnormal pregnancy is found, the woman is referred for obstetric assessment and treatment as soon as possible. If circumstances are normal, the woman is referred for her first midwife examination and an examination at a department of obstetrics, if she so desires.

Second Medical Examination

Progress is assessed at the second medical examination in week 26 of pregnancy. The woman is carefully questioned about significant symptoms, such as bleeding and uterine contractions. Note is made of foetal movement. The woman is recommended to seek prompt medical advice upon significant weight increase, headache, oedema, bleeding, diminishing foetal movement, increasing uterine contractions, or any diffuse symptoms. Any emerging work-related, family or social problems are discussed. The need to consider child care arrangements after the maternity leave ends and is emphasized. The health instruction program is followed up and changes in family circumstances occasioned by the birth discussed to prevent family problems. The importance of midwife examinations and participation in delivery and parenthood preparations are stressed.

The usual objective examination is carried out, uterus size (symphysis-fundus measurements) determined, and foetal heart function checked. The condition of collum and orifice is also explored. The selection of delivery venue is reconsidered and any change noted in the ambulatory patient records.

Third Medical Examination

Preparations for the impending birth are emphasized at this examination in week 35. The woman is informed about signs of early labour and the entire process is reviewed. It is necessary to verify that the woman knows how to act upon onset of labour. In addition, the need for assistance immediately upon her homecoming from the maternity clinic, or upon planned home birth, is clarified.

Clinically, the examination should concentrate assessment of foetal growth, signs of pre-eclampsia, abnormal foetal position, and risk of premature birth (collum shortened). The usual objective examination is carried out and the chosen delivery venue is reviewed and changed, if necessary.

A new blood sample is obtained for antibody testing in conjunction with the third medical examination. The sample is sent to the clinical immunology department with which the maternity clinic collaborates. Test results are evaluated by the woman's own physician and the chosen obstetric department. Based on the results of antibody tests, it is determined whether delivery should take place at a regional obstetric centre with neonatal paediatric facilities capable of exchange transfusion if the infant is at risk of erythroblastosis. The ambulatory patient records are updated.

Medical Examinations Ad Hoc

The woman is advised that, in addition to the three planned preventive health examinations during pregnancy, she should consult her physician if any abnormal symptoms should arise in connection with her pregnancy.

2. Examination by Specialist Obstetrician

At this examination in weeks 16 to 18, which may take place in conjunction with a visit to the delivery venue, it is determined whether delivery date has been accurately calculated and whether any circumstances have arisen that require more careful investigation or treatment. If the specialist examination shows no abnormalities, further examinations are carried out by the family practitioner and the midwife or group of midwives who will assist at delivery. If, on the other hand, conditions require special investigation or treatment, these measures will be arranged by the specialist department in collaboration with the woman's physician and midwife.

3. Health Examination by Midwife

Pregnant women are entitled to at least five examinations by a midwife, the first of which is preferably carried out in week 12 and, if possible, not later than week 20. Further examinations by the midwife may take place as required.

If the woman wishes to give birth at home, one of the subsequent examinations should take place in the home, partly in order to prepare for the necessary practical arrangements.

If a pregnant woman fails to attend a planned examination, the midwife or midwifery centre should attempt to find out why and, if necessary, make a home visit during which the examination may be carried out. The midwife can also offer an examination in the home if special requirements so dictate.

First Midwife Examination

At this examination it is the midwife's task, besides making a physical examination and an assessment of the woman's mental and social status in relation to her pregnancy, to attempt to form an opinion of the woman's individual resources and needs, including her expectations and concerns about the pregnancy and birth. Pregnancy problems are discussed and remedied where possible. The work environment is reviewed and any need for relief evaluated. Subjects such as diet, personal hygiene and lifestyle, economy, participation in preparatory courses for delivery and parenthood, and desired delivery venue should be discussed with the expectant mother. The midwife also delivers various information material, recommends appropriate reading matter, and informs about the health visitor service and, where necessary, about social counselling, welfare, and where so required, how the woman should initiate a paternity suit. The midwife should pay special attention to younger women, primiparas, and women with a different ethnic background. These woman may have special problems.

Subsequent Midwife Examinations

The frequency of contact with the midwife is generally increased as pregnancy progresses. Partly through the delivery and parenthood preparation, the midwife's coordinating role is intensified relative to other professional groups and the delivery venue.

The recommended timing of examinations in normal pregnancies is shown in the schedule. However, the timing can and should be changed when circumstances make it desirable.

Examinations should include a general physical examination, blood pressure checks, urine testing, weighing, and monitoring of uterine growth, foetal heart beat, foetal growth and foetal position. The midwife should attempt to evaluate the woman's mental condition, including her emotional attitude to the coming child, other children and her husband. When necessary, midwife and physician in collaboration with the expectant mother will revise the plan established at the beginning of pregnancy detailing the time and place of examinations and treatment for any health problems. The expectant mother is told to contact her midwife if she passes her expected delivery date (i.e. enters the 41st week).

4. Preparations for Delivery and Parenthood

Preparations for delivery and parenthood consist of theory, physical exercises, and demonstration of delivery room and equipment.

Theory

The theoretical training should include:

- Review of pregnancy and its phases: Foetal development and physical changes in the pregnant woman; psychological aspects and social circumstances affecting the family.
- Review of the complete examination and training program during pregnancy.
- Review of the parturition process, including use of equipment and instruments.
- Review of the confinement period, including introductory infant care and the importance of breast feeding.
- Review of development in early infancy, including motivation for preventive paediatric examinations.
- Discussion of the family's situation after birth, the parental role, relationship to siblings, possible social arrangements, and so on.

Training should be directed by a midwife who also acts as chief instructor. The health visitor is well placed to give training in infant care and feeding. See below concerning the role of the physiotherapist. Physician, psychologist, social counsellor, and relaxation therapist may also participate in the training.

Physical Exercises (Obstetric Physiotherapy)

Pregnancy entails considerable physical changes within a short period. The woman's body awareness and condition critically affect the physical and psychological stress created by pregnancy and birth.

For this reason, delivery preparations include obstetric physiotherapy, arranged and provided by a physiotherapist in collaboration with the midwife or midwifery centre. Specific physiotherapy for any muscle or joint ailments arising in connection with pregnancy, birth, or confinement is provided under the usual rules of medical referral and prescription.

The physical training program is designed to:

- prevent or reduce physical discomfort during pregnancy and maintain/improve general fitness
- train the woman to use her body appropriately during delivery
- by information and exercises, motivate and train the woman to prevent unwanted sequelae and speed recovery after pregnancy and delivery.

Examples of physical discomfort during pregnancy include back and joint pain, muscle pain, circulatory problems, and NY tendency to flat feet.

Examples of sequelae of pregnancy and delivery include pelvic insufficiency, uterine prolapse, prolapse of bladder and intestines, urinary incontinence, abdominal muscle weakness, joint and muscle pain, and poor physical fitness.

Pre- and post-natal exercises are based on principles promoting physical qualities such as muscle power, muscle relaxation and muscle tone, thus improving circulation and general fitness. Techniques include breathing exercises, posture training, neuromuscular control, work techniques, and working positions, as well as pushing techniques and different delivery positions.

Demonstration of Delivery Room and Instruments

Delivery and parenthood preparation should include demonstration of a delivery room and review of practical arrangements for home delivery. This course segment aims to instill confidence in the delivery venue with the woman and her family. The midwife should take this opportunity of inviting the woman to present a "wish list" for the delivery if she has special requests concerning use of procedures or equipment. Practical review of delivery equiment and instruments is a prerequisite for the woman's participation in deciding on the delivery venue and use of instruments.

Post-natal Courses

It is recommended that parenthood preparation continues after delivery to include instruction and practice sessions. These sessions should be a natural continuation of the course given during pregnancy.

The physical training program should begin in the maternity ward or, in the case of ambulatory or home delivery, at home initiated by the midwife. The training program may continue in the post-natal weeks under the direction of a physiotherapist.

Alongside the physical training, instruction in infant care is provided; the importance of breast feeding and changes in family circumstances are mentioned and discussed. This course segment, usually directed by a health visitor, supplements individual counselling and guidance by health visitor or the woman's physician. Establishment of mothers' groups may supplement or replace these courses.

5. Examinations and Procedures in Conjunction with Delivery

The midwife's duties during delivery are specified in the National Board of Health circular concerning midwives dated 8 May 1981, with amendment.

Vitamin K Injections

At one of the final pregnancy examinations the midwife should ensure that the parents are aware of the risk of neonatal bleeding and that such bleeding can best be prevented by injections of Vitamin K for the infant. (Phytomenadione, fluid for injection 0.2%, dose 0.5 ml = 1 mg intramuscularly one to two hours after birth.) Should the parents not wish the child to be injected, the mother should be offered an injection of Vitamin K (Phytomenadione 1%, dose 1 ml = 10 mg i.m.) not later than four hours before the expected conclusion of delivery.

If neither mother nor child has received phytomenadione, the physician should be informed by the midwife.

Prevention of Gonorrhoeal Eye Infection

The midwife's duty to instil lapis drops into the eyes of neonates has been rescinded by National Board of Health dated 26 March 1985. The mandatory lapis treatment has been replaced by rigid hygiene and careful monitoring of the child's eyes during the initial two weeks of life.

The midwife must inform the woman and her husband in conjunction with health examinations thoroughly of the risk that pathogenic bacteria can be transmitted during birth from the mother to the infant's eyes, risking blindness in the event of gonorrhoeal eye infection in the infant. The midwife must furthermore instruct the woman and her husband, late in pregnancy as well as immediately postpartum, that they must inspect the eyes regularly, and that they are obliged immediately to bring the child to a physician if they notice redness or pus formation in one or both eyes within two weeks of birth.

Everyone caring for the child during the first two weeks of life, including midwife, physician, nurse, and health visitor, are obliged to inspect the infant's eyes most carefully and immediately ensure medical treatment if symptoms of conjunctivitis appear.

If the mother has gonorrhoea, or the midwife so suspects, the midwife's duty is to inform a physician, as always where there is suspicion or symptoms of disease.

Upon diagnosis or suspicion of gonorrhoea in the mother or the child, the mother is obliged under Section 3, Law #287 dated 23 May 1973 concerning prevention of venereal disease to have herself examined and, if required, treated by a physician. The child must under all circumstances be treated.

Examination of the Child

The newborn child should be examined by a physician after birth. The purpose of the examination is to diagnose conditions requiring observation or treatment in a neonatology department and to diagnose any birth defects, ensure appropriate notification, and assess the therapeutic options either immediately after birth or at a later stage.

Notification of Birth, etc.

The midwife, under a circular concerning midwives dated 8 May 1981, must report the birth and any birth defects, as well as providing the other reports specified in the circular.

Establishment of Breast Feeding

Midwives and nurses are obliged to assist the mother to establish breast feeding as soon as possible after birth, thus helping to create optimal contact between mother and child and the best conditions for continued breast feeding.

6. Confinement Period

During the confinement period, the mother's need for rest and recovery from delivery should be met while at the same time her ability to care for the child must be taught or refreshed. During confinement, her physical re-training (post-natal gymnastics), including pelvic training, must be initiated as directed by the midwife or physiotherapist. The woman is offered two confinement visits by a midwife. If confinement takes place in a maternity clinic, one visit may take place in the clinic, and the second at home.

The purpose of the confinement visits is to allow the woman (and man) to discuss the delivery process with the midwife involved, and have any questions answered. Confinement visits should also support continued breast feeding in parallel with corresponding efforts by the nursing staff. The midwife should discuss contraception and refer to the physician for medical counselling on the subject. The midwife should inform and motivate the woman to participate in post-natal courses, where possible.

Folling's Disease and Hypothyroidism

At the second confinement visit (days 5-7), the midwife obtains a blood sample from the infant. The sample is sent to the Serum Institute for screening for phenylketonuria and hypothyroidism.

Home Confinement

It is important to coordinate the efforts of various groups to optimize the woman's post-natal recovery, care of her child and family participation in the confinement care. The midwife's initial home visit during confinement after out-patient or home delivery must take place promptly after delivery, preferably within the first 24 hours.

The midwife's assessment of the woman's and family's needs for additional care or practical assistance during confinement after out-patient or home delivery must take place promptly after delivery, preferably within the first 24 hours.

The midwife, having assessed the woman's and family's needs for additional care or practical assistance prior to delivery, is the natural person to arrange contact with local community home nursing and health visitor services for the purpose of confinement care, and set the date for the health visitor's initial visit. The midwife must also report the birth to the woman's own physician so that he or she can make a house call.

Post-natal Examinations

The woman is entitled to one or two medical examinations post-natally by her own physician.

First Post-natal Examination

This examination is offered to women undergoing out-patient or home delivery. It should take place about one week after birth in order that both the mother's and infant's condition may be assessed. If circumstances so require, this examination should take place in the woman's home.

The outcome of the delivery and the woman's condition is discussed. She is examined to ensure that bleeding, healing, and any ruptures, and ensure that breast feeding are progressing normally. Also, the mother/child relationship can be evaluated and problems (e.g. concerning breast feeding or child care) discussed. Preferably, subjects should reflect previous contact between physician, midwife or the health visitor.

Second Post-natal Medical Examination

Applies to all women nine weeks postpartum.

The timing of this examination is chosen to coincide with the infant's second pertussis vaccination.

The mother's postpartum physical condition is evaluated, especially in terms of the healing of any delivery injury or episiotomy wounds, and the recovery of pelvic strength. The need for iron supplments is assessed.

Future contraception is discussed and initiated where appropriate. In addition, changed family conditions, and especially any problems caused by the addition to the family, are discussed. The mother's general condition and opportunities for rest and night sleep are assessed, including the possible need for extending her confinement leave. Often there will be a need to discuss future child care arrangements.

APPENDIX 6

List of Indications for Specialist Care in The Netherlands

List of medical indications for specialist care during pregnancy, labour and the puerperium in the Netherlands (after Kloosterman, 1977).

I. Indications based on the medical and/or obstetrical history

1. Diseases that either influence or are influenced by pregnancy, childbirth or puerperium.

1.1 Neurological diseases, such as epilepsy, subarachnoid haemorrhage, multiple sclerosis, brain tumours, displacement of an intervertebral disc and psychiatric disorders.

1.2 Medical disorders, such as pneumonectomy, lobectomy, active tuberculosis, bronchial asthma, cardiac disorders, Addison's disease, hypo- and hyperthyroidism, thrombosis and embolism.

1.3 Disease and pathology which influence or are influenced by pregnancy, essential hypertension, diabetes mellitus, arteriosclerosis, nephropathy, Rhesus sensitization, severe motor disorders (congenital or acquired), fractures of the pelvis, kyposcoliosis, sequelae of rickets, achondroplasia, previous operations or injuries to the uterus and vagina such as operations for prolapse, previous third-degree perineal tears, cervical conization, myomectomy, vesicovaginal and rectovaginal fistuale, and so on.

An age of 35 years or more for nulliparae and of 45 years or more for multiparae are considered to be an indication for delivery in hospital. Involuntary infertility of over three years' duration also consitutes a 'medical indication'.

2. Diseases that are purely obstetrical. Causes resulting from the obstetrical history that lead to a medical indication.

2.1 Habitual abortion (three or more), perinatal loss in the preceding pregnancy or a total of two perinatal losses, previous delivery between 16 and 37 weeks or a growth-retarded infant which required special care in the preceding pregnancy; if the preceding infant was born in bad condition, required resuscitation and/or has a handicap that can be ascribed to birth trauma; postpartum haemorrhage of 1000 ml or more and/or blood transfusion and/or manual removal of the placenta and/or shock, caesarean section, third-degree tear, abruptio placentae, symphysiolysis, severe pre-eclampsia requiring hospitalization in the preceding pregnancy, symptomatic pre-eclampsia, eclampsia, puerperal psychosis, thrombosis or embolism.

II. Indications that result from the first antenatal examination

Severe hypertension, proteinuria of 100 mg or more per 24 hours, pelvic tumours or severe anaemia.

III. Indications that may arise during the antenatal period

1. Obstetrical indications for admission to hospital in the first half of pregnancy

1.1 Severe haemorrhage.

1.2 Hyperemesis gravidarum with acetonuria.

1.3 Suspected molar pregnancy.

1.4 Abortion of a molar pregnancy.

1.5 Suspected extra-uterine pregnancy.

1.6 Ovarian cyst or tumour, requiring treatment.

2. Obstetrical indications for admission to hospital in the second half of pregnancy

2.1 Severe toxaemia (blood pressure of 150/95 on at least two separate occasions, proteinuria in excess of 100 mg per 24 hours, pre-eclampsia or eclampsia).

2.2 Blood-loss in the second half of pregnancy.

2.3 Onset of labour after the 22nd and before the 37th week (260 days).

2.4 Strongly suspected intra-uterine growth retardation.

2.5 Leakage of amniotic fluid.

2.6 Symptomatic polyhydramnios.

2.7 Pyelonephritis.

3. Obstetrical indications for admission to hospital arising in late pregnancy

3.1 Proven or probable fetal malformations detected by antenatal diagnosis.

3.2 Multiple pregnancy.

3.3 All malpositions, such as breech presentation, oblique position, transverse lie and so on, which are present after the 36th week.

3.4 A diagonal conjugate of less than 11 cm.

3.5 Overt disproportion.

3.6 Non-engaged head in the last four weeks of pregnancy in nulliparae.

3.7 Failed attempts to fit the fetal head into the pelvis in both nulliparae and multiparae.

3.8 Fetal death.

3.9 Unstable lie after the 36th week.

3.10 Rhesus sensitization.

3.11 Postmaturity, defined as more than 294 days for nulliparous and more than 301 days for multiparous women.

3.12 Abdominal surgery after the 26th week of gestation.

IV. Indications arising during labour and immediately postpartum

1. Indications for admission during labour

1.1 Malposition.

1.2 Signs of fetal distress, such as meconium-stained liquor, decelerations in fetal heart-rate.

1.3 Absence of labour 12 hours after rupture of the membranes.

1.4 Poor progress in second stage, with need for intervention.

1.5 Blood-loss during labour.

1.6 Abruptio placentae.

1.7 Vasa praevia.

2. Indications for admission in the immediate postpartum period

2.1 Any excessive blood-loss before or after delivery of the placenta that does not respond rapidly to treatment.

2.2 Retained placenta.

2.3 Third-degree perineal tear.

2.4 Separation of the symphysis pubis.

V. Indications in the puerperium

1. For the mother

1.1 Vulval haematoma, particularly when associated with disorders of micturition.

1.2 Serious puerperal infection with systemic illness, particularly when not responding to therapy.

1.3 Puerperal psychosis within 36 hours.

1.4 Thrombosis.

2. For the child

2.1 Growth-retarded and/or premature infant; a weight below 2000g always constitutes an indication; a weight between 2000 and 2500g virtually always constitutes an indication unless the general condition of the infant and facilities for adequate care and surveillance allow an exception to be made.

2.2 Any infant in excess of 2500g for reasons such as cyanosis, hypothermia, tracheo-oesophaegeal fistula, anal atresia, cleft palate which hinders feeding, jaundice within 24 hours or severe jaundice beyond that period.

VI. Those women who should be allowed to deliver at home

A woman is eligible for home delivery if:

1. She is healthy.

2. She shows no signs of toxaemia.

3. She has a singleton pregnancy with cephalic presentation and no cephalo-pelvic disproportion.

4. The fetal head is engaged in the last weeks of pregnancy or can at least be brought into contact with the pelvis.

5. There is no pathology (apart from abortion) in her obstetrical history.

6. She is a primigravida under 35 years of age or a multigravida under 45 years of age.

7. Labour starts spontaneously after the 36th week and before the 43rd week (45th week for multiparae).

Furthermore, social circumstances should be such that she has a separate bedroom with adequate heating, running water and easy access to a toilet, and that, in case of an emergency, she can be easily transported on a stretcher to the nearest hospital within one hour.

APPENDIX 7

Association of Ontario Midwives—Standards for Practice

The AOM standards for practice were adopted from the standards and qualifications drawn up by the Midwives Alliance of North America (MANA). They state:

1. *Skills*

Necessary skills of a practising midwife include the ability to: provide continuity of care to the woman and her family during the maternity cycle, continuing interconceptionally throughout the childbearing years; assess and manage normal antepartal, postpartal and neonatal periods; identify and assess deviations from normal; maintain proficiency in life-saving measures by regular review and practice; manage emergency situations appropriately. It is affirmed that judgment and intuition play a role in the assessment and response to specific situations.

2. *Appropriate Equipment*

All midwives should be equipped to assess maternal, foetal and newborn wellbeing; to maintain a clean and/or aseptic technique; to treat maternal haemorrhage; and to resuscitate mother or infant.

3. *Records*

All midwives will keep accurate records of care provided for each client such as are acceptable in current midwifery practice. Other records should be maintained as deemed necessary by law.

4. *Compliance*

Midwives will comply with Public Health requirements of the jurisdiction in which midwifery practice will occur.

5. *Medical Backup*

All midwives recognize that there are certain conditions when medical consultations are advisable. The midwife shall make a reasonable attempt to assure that her client has access to consultation and/or referral to a medical care system when indicated.

6. *Screening*

Midwifery practice upholds the right to self-determination of consumers within the boundaries of safe care. It is the responsibility of the midwife to use risk screening and to make appropriate referrals when indicated for the protection of the mother, baby, or midwife.

7. *Informed Choice*

Each midwife will present to each potential client accurate information about herself and her services, including but not limited to:

a) her education in midwifery

b) her experience level in midwifery

c) her protocols and standards

d) her financial charges for services

e) the services she provides to her clients and the responsibilities of the pregnant woman and her family.

8. *Continuing Education*

Midwives will update their knowledge and skills pertinent to maternity care. For each two-year period, sixteen (16) contact hours of continuing education must be obtained. Suitable topics include but are not limited to midwifery management in the antepartum, intrapartum, postpartum and newborn periods, risk assessment, early recognition of potential problems, midwifery management of emergency situations, ethics, legal aspects of practice, and childbirth education. Continuing education may be obtained through organized courses, conferences, area midwives' meetings or other means as approved by MANA.

9. *Peer Review*

Midwifery practice includes an ongoing process of evaluation. Case review with peers on a regular basis is recommended.

10. *Protocols*

Each midwife will develop protocols for her services that are in agreement with the basic philosophy of MANA and reflective of currently accepted midwifery practice in her jurisdiction. These shall be written and maintained on file by the midwife.

APPENDIX 8

Society of Obstetricians and Gynaecologists of Canada

Guidelines for Prenatal Care (Part 1)
Statement on Electronic Fetal Monitoring (Part 2)

Guidelines for Prenatal Care in Canada—1984

Introduction

The goal of modern obstetrical care is to reduce perinatal morbidity and mortality to an absolute minimum. We wish to assure that every baby conceived attains its full mental, social, physical and genetic potential while at the same time promoting maternal health. These aims would be achieved by education, psycho-social support, medical and technical expertise throughout the pregnancy.

Antenatal Care

1. Preconceptional Care

The woman should be seen by her physician before she is pregnant to permit safe discontinuation of contraception, obtain genetic counselling where indicated and suggest alteration of life style including smoking, excess alcohol intake, poor nutrition, exercise and control of existing disease states. In certain cases consultation by an obstetrician-gynaecologist may be required.

2. Visits

The woman should be seen as soon as pregnancy is suspected, ideally within four (4) weeks of conception. A complete history should be taken, including present and past illnesses, obstetric and genetic history and use of medications including cigarettes, street drugs and alcohol. A general physical examination should be performed, including pelvic examination to estimate uterine size, and laboratory examination should include a serologic test for syphilis, pap smear (if not done with the past 6 months), routine urinalysis, urine for culture and sensitivity, rubella titre, blood group, blood antibody screen, hemoglobin and where indicated biochemical confirmation of pregnancy. Other tests may be performed as indicated. For example: cultures for gonococcus or herpes; tests for hepatitis or toxoplasmosis in areas of high prevalence; sickle cell prep., thalasemic screen, Tay-Sachs and diabetes mellitus testing for at-risk groups.

The woman should be followed monthly to 28 weeks gestation, and then every 2 to 3 weeks to 36 weeks and then every 1 to 2 weeks to delivery. Each visit should include the patient's weight, blood pressure, urinalysis for protein and glucose, growth of the uterus (symphysis-fundus height) and documentation of foetal heart rate. Plans for management of the pregnancy should be reviewed discussing aspects including the father's role, prenatal classes, preparation for breast feeding, diet and exercise. Discussion should take place regarding the patient's birthing plan for labour and delivery.

Risk scoring should be performed at each visit. Use of the provincial standardized prenatal forms should be encouraged.

3. Continuity of Care

The physician responsible for prenatal care should also be responsible for delivery. In some circumstances shared care may be unavoidable. One physician may undertake the bulk of antenatal care when another will be involved with the delivery. In those circumstances, early referral to and subsequent follow-up by the physician who will delivery the patient is *mandatory*.

4. Special Tests

Good clinical judgement will indicate the need for other investigations such as ultrasound, amniocentesis, foetal monitoring and biophysical profile. It is recommended that all patients be screened at 28 to 30 weeks gestation for diabetes by appropriate blood sugar tests or a glucose tolerance test. If there is a question of dates or uterine size discrepancy, early ultrasound between 16-20 weeks and a repeat within 4 weeks, if indicated, would be used to establish accurate dates. Amniocentesis for genetic reasons should be done under ultrasound control. Electronic foetal monitoring and/or biophysical profile is reserved for high risk patients and should begin when indicated and repeated as necessary. Daily foetal movement counting by the patient may supplement these tests. If the woman is Rh negative unsensitized, and the father of the baby is Rh positive, Rh immune globulin is indicated at 28 weeks gestation. If the baby is Rh positive and the mother remains unsensitized, a further dose of Rh immune globulin is indicated within 72 hours of delivery. Although not available to all centres, a Kleihauer test ideally should be performed prior to Rh immune globulin administration to detect the rare case where additional Rh immune globulin would be required.

5. Diet and Medications

Maternal self-medication should be discouraged. Use of prescribed medications during pregnancy must weigh possible foetal hazards against benefits to the mother.

A well-balanced diet is encouraged and supplementation with iron and folic acid may be indicated.

6. Regionalization of Care

Regionalization of perinatal care is highly desirable. Where risk scoring indicates a pregnancy is at risk, the woman should be referred to a consultant or regional perinatal unit. The regional unit will provide consultative services, necessary expertise and special procedures and will suggest guidelines for further management of the woman.

Plans for Intrapartum Care

To assure ideal outcome for mother and her baby, appropriate nursing support, personnel and technology should be available. In spite of technological aides to safe delivery, attempts should be made to make the birth experience a happy and fulfilling one for the family. Labour, delivery, recovery and postpartum units should be made available to promote family-centered maternity care.

With the exception of primary care obstetrical units, continuous onsite obstetrical, neonatal and anaesthetic coverage must be available in the delivery area.

Ideally, deliveries should occur in an accredited hospital maternity unit. We strongly disapprove of home births as not being in the best interests of either mothers or infants. Any free-standing childbirth centre should have physical and organizational attachment to an existing accredited maternity centre.

Plans for Postpartum Care

The mother and her newborn should be medically stable prior to *discharge*. Early *discharge* (within 24 hours) could occur if satisfactory arrangements for home follow-up are available in the community. Parents should be competent and confident in the handling of their newborn at *discharge*. The mother should be instructed to contact her physician if problems arise. Before *discharge*, a postnatal examination appointment at 6 weeks should be arranged.

At the postnatal visit the physician should review concerns about pregnancy, labour, delivery and postpartum events. A discussion of the mother's health since delivery and her need for contraception is important. An appropriate *examination* including pelvic *examination* and pap smear is performed with other investigations and/or counselling as indicated.

Quality Assurance

Peer review of specific cases is an important component of quality assurance for perinatal services. Periodic hospital audit of perinatal procedures and performance is essential. Establishment of regional and hospital based maternal mortality and perinatal mortality and morbidity committees is needed to achieve this goal.

Statement on Electronic Fetal Monitoring

The addition of electronic fetal monitoring (EFM) to the clinical armamentarium for fetal surveillance offers great potential benefits, but there are also significant risks if the procedure is used indiscriminately. Therefore we believe it advisable to present in the Bulletin the conclusions of the Task Force appointed by the American National Institutes of Health to furnish guidance on this important subject. The communication published below deals with a number of considerations attention to which should reduce the risks and increase the benefits of EFM.

Recommendations

A. Current Clinical Practice

The Task Force recognizes that pregnant women and those who attend them are now confronted with decisions regarding optimum intrapartum care which must necessarily be based upon incomplete information. The conclusions reached by the Task Force do however provide a basis for the following recommendations for current obstetrical practice:

1. Electronic fetal monitoring or any other technology should never be a substitute for clinical judgment. Electronic fetal monitoring is only one parameter of fetal assessment.

2. Proper use of both intermittent auscultation and continuous electronic fetal monitoring in both high and low risk patients should at the outset include a discussion with the patient of her wishes, concerns and questions concerning benefits, limitations and risks of fetal monitoring. Women should have the opportunity to discuss the use of all forms of monitoring during the course of prenatal care, and again upon admission to the labor suite. The use of all forms of monitoring should be accompanied by supportive and knowledgeable personnelle who are attentive to the patient's expectations regarding the conduct of her labor. Hospital personnel should be cognizant of the potential impact of EFM upon family centered childbirth.

3. Periodic auscultation of the fetal heart rate (for 30 seconds every fifteen minutes in the first stage of labor and every 5 minutes during the second stage; immediately following a contraction) is an acceptable method of assessment of fetal condition for women at low risk of intrapartum fetal distress. Interpretation of auscultated FHR data should include an understanding of the relationship of FHR changes to uterine contractions. Although the Task Force finds that the weight of present evidence does not show benefit of electronic fetal monitoring in low risk patients, it recognizes that under certain circumstances, mothers or physicians may choose to use electronic fetal monitoring in low risk patients.

4. The use of electronic fetal monitoring should be strongly considered in high risk patients. Some of the high risk situations may include: 1) low birth weight, prematurity, postmaturity and intrauterine growth retardation; 2) medical complications of pregnancy; 3) meconium staining of the amniotic fluid; 4) intrapartum obstetrical complications; 5) use of oxytocin in labor; and 6) the presence of abnormal auscultatory findings.

The medical record should reflect careful consideration of the benefits and risks to each individual including a discussion of the indications for EFM.

5. Since unexpected risk factors may arise during labour in patients without prior evidence of risk, all hospitals and

birthing centres providing maternity care should have the necessary trained staff and equipment to assess carefully the status of each fetus in labor and to take appropriate action.

6. In order that electronic fetal monitoring be used appropriately, the medical profession and other should encourage, through their various educational modalities, a thorough understanding of the principles and procedures of intrapartum fetal heart rate assessment, by all personnel responsible for the care of pregnant women. Special attention should be given to the benefits, limitations, and risks of each mode of assessment. Acquisition of expertise in the use of continuous fetal heart rate and intrauterine pressure data requires the opportunity for supervised practical training in the interpretation of monitor tracings, use of scalp blood sampling, and the integration of such data into the clinical setting.

7. The use of fetal scalp blood pH determination is strongly encouraged as an adjunct to electronic fetal heart rate monitoring.

8. Attention to the known potential hazards of EFM should accompany its use. Placement of the fetal scalp electrode and intrauterine pressure catheter should be performed with attention to aseptic and atraumatic technique. Prolonged supine position of the mother should be avoided and maternal mobility should not be unnecessarily limited.

9. Hospital personnel should be cognizant of the potential impact of EFM upon family centered childbirth. Family centered care and indicated intrapartum fetal monitoring are not mutually exclusive. Maternity services should be encouraged to integrate concepts of family centered care with care of women who are electronically monitored.

B. *Future Research*

1. Research into the effect of hypoxia upon the developing fetus and newborn should be encouraged. The long term neurologic sequelae of intrapartum hypoxia are of particular importance. Specific attention should be directed to the prognostic value of various modes of fetal assessment during labor.

APPENDIX 9

Glossary and List of Abbreviations Used in the Text

Glossary of Terms

Afterbirth	See Placenta.
Amniocentesis	The removal of a small amount of amniotic fluid through the pregnant woman's abdomen using a sterile needle and syringe. Usually done to test the fluid for foetal defect or maturity.
Amniotomy	The rupturing of the amniotic sac using a sterile instrument. Sometimes done to induce or speed up labour.
Analgesics	Pain killing agents that do not induce unconsciousness.
Anaesthetic	Medication that produces partial or complete insensibility to pain.
Anaesthetic, general	Anesthetic that affects the whole body, usually with loss of consciousness.
Antenatal or Antepartum	Often used interchangeably with each other and with prenatal. The time before birth.
Antihaemorraghic	1) preventing or arresting haemorrhage. 2) agent that prevents or arrests a haemorrhage.
Apgar Score	A general test of the baby's wellbeing given immediately after birth to ascertain the heart rate and tone, respiration, blood circulation and nerve responses, named after Dr. Virginia Apgar.
Cervix	The lower entrance to the uterus, or neck of the womb.
Confinement	The period of childbirth.
Congenital Abnormality	An abnormality or deformity existing from birth usually arising from a damaged gene, the adverse effect of certain drugs, or the effect of some diseases during pregnancy.
Edema	A local or generalized condition in which the body tissues contain an excessive amount of fluid.
Electronic Foetal Monitoring	The continuous monitoring of the foetal heart by a transducer placed on the mother's abdomen over the area of the foetal heart or an electrode inserted through the cervix and clipped to the baby's scalp.

Epidural	(Lumbar epidural block) Regional anesthesia, used during labour for Cesarean sections, in which an anesthetic is injected through a catheter into the epidural space in the lower spine.
Episiotomy	Surgical cut in perineum to enlarge the vaginal opening.
Foetus	The developing child in the uterus from the end of the embryonic stage, at about the 12th week of pregnancy, until the date of delivery.
Full term	An infant born between 38 to 42 weeks of gestation.
Fundus	The upper part of the uterus.
Gestation	Pregnancy. Its duration is normally measured from the first day of the last menstrual period.
Haemorrhage	Excessive bleeding.
Iatrogenic	Caused by the process of diagnosis or treatment.
Induction	(Of labour or abortion). Process by which labour is initiated artificially, often by intravenous drip or amniotomy.
Intrapartum	During labour.
Intrauterine	Inside the uterus (womb).
Intravenous fluids (IV)	Sterile solutions administered directly into a vein.
Intubation	Insertion of a tube into the trachea (windpipe) to permit air or air/oxygen mixtures to enter the lungs.
Labour	The physiological process by which the baby is gradually expelled from the uterus into the vagina and then to the outside of the body. Syn. Childbirth; Parturition.
	First Stage: (stage of dilatation). Period from the onset of regular contractions of the uterus until the cervix is fully dilated. Averages 12 hours in primigravidas and eight in multiparas, but may be much shorter or longer.

	Second Stage: (stage of expulsion). Period from complete dilatation of the cervix through the birth of the baby. Averages 50 minutes duration in primigravidas and 20 minutes in multigravidas.
	Third Stage: (placental stage). Period following birth of the baby through delivery of the placenta and membranes. As soon as the foetus is delivered, the remainder of the amniotic fluid escapes. This will contain a small amount of blood. Uterine contractions and pains begin, and usually within eight to ten minutes the placenta and membranes are delivered. Following this, there is a certain amount of bleeding from the uterus. The amount may vary from 100 to 500 ml. or more, but the average is 200 ml.
Live birth	A baby which has breathed or shown any other sign of life at birth such as the beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.
Morbidity	Illness, disease, abnormality.
Multigravida	A woman in her second or subsequent pregnancy.
Multipara	A woman who has borne more than one child.
Neonatal death	Death within 28 days of live birth.
Obstetrics	The medical and surgical specialty concerned with pregnancy, delivery and puerperium.
Paediatrics	Medical specialty concerned with the care of babies and children.
Parturition	Act of giving birth.
Perinatal Period	Concerning the time after the 28th week of pregnancy through 28 days following birth.
Perinatal Mortality Rate	The number of stillbirths plus the number of deaths occurring in the perinatal period as a rate per 1,000 live and stillbirths.
Perineum	Area of pelvic floor between vagina and anus.
Phenylketonuria (PKU)	Problem of metabolism. All infants must be tested for PKU with a blood test after feeding is established.
Placenta	The organ which develops on the inner wall of the uterus and supplies the foetus with all its life-supporting requirements and carries waste products to the mother's system.
Postnatal or Postpartum	Used interchangeably. Means the time after birth. (See puerperium)
Pre-eclampsia	An illness in which a woman has high blood pressure, edema, albumin in the urine and often an excessive weight gain.
Primipara	A woman who has given birth, or is giving birth to her first child.
Puerperium	4-6 week period after delivery during which the mother's body readjusts to a non-pregnant condition.
Rate	The speed of frequency of occurrence of event. Usually expressed with respect to time of some other known standard.
Rubella	A mild virus which may cause congenital abnormalities in the foetus if contracted by a woman during the first 12 weeks of pregnancy.
Stillbirth	An infant delivered after the 28th week of pregnancy which did not breathe or show any signs of life.
Symphysis Pubis	The place where the pubic bones join—the front bones of the pelvis.
Teratogenesis	The production of physical defects in the embryo. A teratogenic drug is a drug which, when administered to a pregnant mother, induces some physical defect in her unborn child. The term has come into common usage since the thalidomide disaster.
Ultrasound Scan	A way of building up a picture of an object by bouncing high frequency sound waves off of it. The sonar or ultrasound scan is used during pregnancy to show the development of the foetus in the uterus.

List of Abbreviations Used in the Text

ACNM - American College of Nurse Midwives
ACOG - American College of Obstetricians & Gynaecologists
AOM - Association of Ontario Midwives
CAAT - College of Applied Arts and Technology
CCHA - Canadian Council on Hospital Accreditation
CHC - Community Health Centre
CICH - Canadian Institute of Child Health
CMA - Canadian Medical Association
CNM - Certified Nurse Midwife
CNO - College of Nurses of Ontario
COFM - Council of Faculties of Medicine
CPSO - College of Physicians & Surgeons of Ontario
GFT - Geographic Full Time Professor
HSO - Health Service Organization
ICM - International Confederation of Midwives
MAC - Medical Advisory Committee
MANA - Midwives Alliance of North America
MCU - Ministry of Colleges and Universities
NHS - National Health Service
OARNA - Ontario Association of Registered Nursing Assistants
OHA - Ontario Hospital Association
OMA - Ontario Medical Association
ONA - Ontario Nurses Association
ORCAUSN - Ontario Region, Canadian Association of University Schools of Nursing
OSCE - Objective Structured Clinical Examination
RNAO - Registered Nurses Association of Ontario
SOGC - Society of Obstetricians & Gynaecologists of Canada
UKCC - United Kingdom Central Council
VBAC - Vaginal Birth After Caesarean
VON - Victorian Order of Nurses
WHO - World Health Organization

APPENDIX 10

Biographies of the Task Force Members and Staff

Members of the Task Force

Mary Eberts, Chairperson

Ms Eberts is a partner with the Toronto law firm of Tory, Tory, DesLauriers and Binnington where she practises in the area of civil litigation. She has served on many boards and commissions including the Special Committee on Pornography and Prostitution. She has been counsel to the Canadian Advisory Council on the Status of Women and the Canadian Civil Liberties Association. Ms Eberts has written and spoken widely on the subject of equality rights under the Charter of Rights. She is active in many community organizations including the Metro Action Committee on Public Violence Against Women and Children and the Ontario Committee on the Status of Women.

Ms Eberts lives in Toronto with her husband and three school-aged children.

Alan M. Schwartz, Q.C., Vice-Chairperson

Mr. Schwartz is a partner with the Toronto law firm of Fogler, Rubinoff where he practises in the areas of administrative law, strategic planning and public policy. He has acted as counsel to various Ontario Select Committees on Hydro Affairs and the Select Committee on Highway Safety. In 1983, he was named to head The Ontario Health Professions Legislation Review. He is active in several community organizations and is a director of the Art Gallery at Harbourfront, the Toronto Sculpture Garden, the Professional Art Dealers Association Foundation and the Canadian Technion Society.

Mr. Schwartz lives in Toronto with his wife and young daughter.

Rachel Edney

Dr. Edney is a family practitioner affiliated with Etobicoke General Hospital. Obstetrics is an important part of her practice and she currently attends at about 70 deliveries per year. Dr. Edney is active in the College of Family Physicians of Canada and was president of the London Chapter in 1966. From 1981-84 she served on the Executive of the Ontario Chapter and was President during 1984-85.

Dr. Edney lives in Etobicoke with her husband and four children.

Karyn Kaufman

Dr. Kaufman is Associate Professor at McMaster University School of Nursing and a clinical nurse specialist at Chedoke-McMaster Hospitals. She is also a Certified Nurse-Midwife. She was a member of the Registered Nurses' Association of Ontario Task Force on Nurse-Midwifery and in 1985 was a member of the Ad Hoc Committee of the RNAO that reviewed and recomended changes to the RNAO Statement on Nurse-Midwifery. Dr. Kaufman has written widely on midwifery care and various aspects of labour and breastfeeding.

Dr. Kaufman lives in Burlington with her husband and two children.

Staff of the Task Force

Linda S. Bohnen, Executive Director

Ms Bohnen was educated at York University and at the Faculty of Law of the University of Toronto. She has worked as a journalist and with the Ontario Ombudsman.

Ms Bohnen lives in Toronto with her husband and school-aged daughter.

Hildy Abrams, Manager of Administration

Ms Abrams was educated at McGill University and at the Wurzweiller School of Social Work, Yeshiva University, New York. She has worked as a social worker at the Whitby Psychiatric Hospital and as a Management Intern for the Ministry of Health.

Ms Abrams lives in Toronto with her husband and young daughter.

Wong Yuk Yin, Bibliographer

Ms Wong has recently completed her Master of Library and Information Science degree at the University of Toronto. She holds Master's degrees in the History and Philosophy of Science (Pittsburgh), the History and Philosophy of Science and Technology (University of Toronto) and the History of Ideas (Malaysia). Ms. Wong is fluent in English, French, and Cantonese.

Jutta Mason, Historian

Ms Mason's interest in midwifery is longstanding. As a Registered Nurse and historian she worked for 11 years in hospitals in both urban and remote locations and has compiled research on childbirth practices. She recently completed a chapter for a book edited by Sheila Kitzinger and is working on a history of health care in Canada.

Ms Mason lives in Toronto with her husband and three children.

Kate Hughes

Ms Hughes is a lawyer in practice with the Toronto law firm of Symes, Kitely and McIntyre. She specializes in the areas of employment, health and family law. Ms Hughes summarized the submissions received by the Task Force (Appendix 2).

The Task Force is especially grateful to Miss Julie Cordwell, who typed the manuscript, and Mr. Greg Ioannou, who served as editor.